St. Vincent Care Homes Limited

Magnolia House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Magnolia House is a residential care home providing personal care for up to 40 people. The care home accommodates people within one large, adapted building, with access to floors by lifts or staircases. The service provides support to older people whose needs included physical needs and dementia. At the time of our inspection there were 29 people using the service.

People's experience of using this service and what we found
Whilst people and their relatives told us they felt safe in the service, we found risks to people were not safely managed. Risks had not always been assessed or monitored and staff did not have guidance to effectively reduce those risks. Care plans and risk assessments did not identify essential information to ensure people were supported in a safe way.

People were not receiving safe care. For example, staff did not have sufficient information to be able to ensure they understood how to manage risks to people from pressure injuries, choking risks, falls, specific health conditions and behaviours that posed a risk to others.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff had not all received up to date training in safeguarding. Although they were able to describe actions they would take if they suspected or witnessed any abuse, we found not all safeguarding incidents had been acted upon. This meant people had continued to be at risk of harm.

There was a process in place for incidents and accidents to be recorded. However, records we reviewed were not always fully completed and had not been reviewed by the management team. This was important to ensure action could be taken to address issues when needed and prevent a reoccurrence.

Not all staff had received appropriate training to ensure they had the skills and knowledge to effectively support people. Staff had not had regular supervision to ensure they were helped to develop their skills and supported in their role.

Staff response times to people using their call bells for assistance were very poor. The management team had not carried out audits of the call bell system, which would have enabled them to identify where improvements were needed. This meant we were not assured people received support in a timely way.

People were not always treated with dignity and respect and staff were task focussed. We observed staff interactions with people using our short observational framework. This showed although some staff spoke to people with kindness and were caring, those people who were unable to easily hold conversations did

not receive meaningful engagement from staff.

People received enough to eat and drink and told us they enjoyed the food. However, information was not clearly recorded when people needed a modified diet or were at risk of choking.

People were supported to access healthcare services when required. However, information relating to people's health needs was not always clearly documented within people's care plans.

Most people and their relatives told us they understood how to complain and would feel comfortable to do so. However, the leadership of the service was poor with limited management oversight. Quality and safety monitoring systems were not robust. This meant the provider and registered manager could not be proactive in identifying issues and concerns in a timely way and acting on these.

Governance processes and systems in place to help ensure the safe running of the service had not identified all the concerns we found. CQC had not been notified of significant events as required. This led to missed opportunities for ensuring the quality of care people received was of a good standard and safe.

Recruitment processes were safe to ensure only suitable people were employed. The service was clean and infection control measures were in place. People's medicines were managed and administered safely.

People and relatives felt staff were kind and welcoming. We observed staff speaking to people with kindness.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 30 September 2017).

Why we inspected
The inspection was prompted in part due to concerns received about how the service assessed and met people's needs and managed risks. A decision was made for us to inspect and examine those risks.

In addition, the inspection was prompted in part by notifications of two incidents following which, 1 person using the service died and another came to serious harm. These incidents are subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of these incidents. However, the information shared with CQC about these incidents indicated potential concerns about the management of risk of falls and monitoring in place and the management of behaviours that pose a risk to others. This inspection examined those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Magnolia House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, staffing, consent, dignity, governance and failing to notify the commission of significant events, at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Magnolia House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by 1 inspector and an Expert by Experience on the first day and 1 inspector on the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Magnolia House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Magnolia House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

Both days of this inspection were unannounced.

Inspection activity started on 12 May 2023 and ended on 2 June 2023. We visited the service on 12 and 16 May 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including the statutory notifications we had received from the provider. Statutory notifications are reports about changes, events or incidents the provider is legally obliged to send to us. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 4 relatives about their experience of the care provided. We reviewed a range of records. This included 12 people's care records and 6 people's medicines records. We looked at 3 staff files in relation to recruitment and induction. A variety of records relating to the management of the service, including accident and incident records, safeguarding and policies and procedures were reviewed.
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 9 staff members including the provider, the provider's senior manager, the registered manager, the deputy manager, and care staff. We spoke to and/or received written feedback from 6 external professionals.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks to people were not managed and mitigated effectively. Although people told us they felt safe, we found risks were not assessed and there was no, or limited guidance for staff. This was important to ensure staff understood what actions they needed to take to keep people safe. For example, we saw one person expressed distress or agitation in a way that could be a risk to themselves or others. There was no risk assessment in their care plan to guide staff on how to manage this risk or how best to support the person to reduce their distress or agitation.

● Another person had a food allergy. There was no information or guidance for staff about how to mitigate this risk or what action to take if the person showed signs and symptoms of an allergic reaction. We discussed the lack of information about known risks with the registered manager during the inspection. Following our inspection risk assessments were completed in relation to some of these risks. However, these lacked detail to ensure staff had sufficient information to reduce and manage all the risks.

● Some people had a diagnosis of diabetes. Risk assessments had not always been completed and where they were, they lacked sufficient information to guide staff so they would recognise changes to people's health and take any required action. For example, one person who had a diagnosis of diabetes, did not have an associated risk assessment in place. We discussed this with the registered manager and following our inspection visit, one was completed. However, the risk assessment lacked sufficient information to mitigate the risks. This placed people at risk of harm.

● People who were at risk of developing pressure injuries or who already had pressure injuries, were not having their needs safely met. Pressure injuries can develop when people are unable to re-position themselves and have poor skin integrity due to their associated health needs. Information about how to reduce these risks, or to aid healing, was not recorded in their care plans. For example, one person's care plan identified they had a pressure injury. The person needed staff support using a hoist, to move. There was no information in their care records about how staff should reduce the risks, if any pressure relieving equipment was in use, or how frequently the person should be moved to reduce pressure on their skin. Although, there was a repositioning chart in place, this did not describe how often the person should be re-positioned and indicated the person had long periods of time when they were not moved. This placed them at risk of the pressure injury getting worse and did not aid their healing.

● Another person's care plan identified they were at high risk of poor skin integrity as they were low in weight, had poor fluid intake due to their frailty, and were cared for in bed. They had developed a pressure injury and had a re-positioning chart in place which we reviewed. Their care plan identified they should be moved 2-hourly during the day and 4-hourly at night. Records showed multiple days where they were not moved for between 7 and 15 hours. This meant people were at risk of harm. Furthermore, people's care plans did not identify clearly if pressure relieving equipment was in use. Although there was a chart for staff to record when they had completed a 'mattress check,' this did not describe what staff were checking for, or

the setting any air mattresses should be on. This was important to ensure air mattresses were set correctly for each person's individual need.

● Where speech and language therapists (SALT) had assessed people to need a modified diet or liquids thickening due to a risk from choking, their needs were not safely managed. Care plans lacked sufficient information and risk assessments had not always been completed to describe how each person should be supported to minimise these risks. For example, in one part of a person's care plan, it identified they required a modified diet and had a health condition, which increased their risks of choking when eating and drinking. There was no risk assessment or information in their care plan that guided staff with clear consistent information about how to mitigate them.

● Another person was cared for in bed and had been assessed by SALT to require a modified diet. There was no guidance or risk assessment in place to ensure staff understood how to minimise the risks and what to do in the event of them choking. We discussed this with the registered manager during the inspection and nutrition assessments were completed. However, there were no choking risk assessments in place. We discussed this with the provider who told us they would take immediate action to ensure all people who required risk assessments for choking were in place.

● Where people had falls, head injury monitoring procedures were not being followed where required. This is important as people who have a cognitive impairment, cannot always tell staff if they have hit their head when they fell. Although some monitoring measures were taken, this was not consistent. For example, we viewed accident and incident records. For two people who had fallen, although relevant medical advice was sought, head injury monitoring was indicated, and this monitoring was not evident or recorded. This meant people were at risk of harm of staff not identifying changes to people's presentation and taking any urgent action required. We discussed this with the registered manager and provider, who assured us they would immediately implement staff recording head injury monitoring. We acknowledge some staff have now received training, which had already been planned by the provider prior to the start of the inspection, to address this.

The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were fire safety arrangements in place and fire risk assessments had been completed by a suitably qualified professional. Personal evacuation and escape plans had been completed for each person; detailing action needed to support people to evacuate the building in the event of an emergency. However, information about how many staff had received fire training was not clear. This meant we were not assured all staff had received fire training or that robust systems were in place to ensure refresher training was completed when required. More information about staff training can be found in the effective part of this report.

● Equipment, including, hoists and lifts were serviced and checked regularly. Additionally, gas and electrical safety certificates were up to date and the service took appropriate action to reduce potential risks relating to Legionella disease.

Learning lessons when things go wrong

● When incidents or accidents happened, electronic records were made by staff on the provider's care records system. However, the records made were not sufficiently detailed and were not consistently reviewed by the management team. When they had been reviewed, there was no detail to describe if action had been taken to reduce the likelihood of the incident reoccurring or to identify if there were any patterns or themes. This was important to ensure where people had known risks, a robust review of their associated risk assessment or the completion of new risk assessment was conducted. This meant up to date

information was not available to staff so they could keep people safe.
● We reviewed the record of one person who had fallen. The record of the accident stated they had a large bump on their head. Although staff carried out immediate first aid and the person was then assessed in hospital; there was no management review of the accident to demonstrate if any changes were needed to prevent it reoccurring in the future.
●We reviewed an incident report which described one person, who lived with dementia, attempted to assist another person to stand up from their chair. The person being pulled up was unable to stand independently and had been assessed to need a hoist for all mobility. There had been no consideration to the ongoing risk, including completing a risk assessment or ensuring there was clear guidance for staff about how to mitigate the risk of this occurring again. This placed the person and other people at continued risk of harm.

The failure to investigate and review risks arising from incidents that had occurred and to reduce the likelihood of a reoccurrence is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
● There was a lack of evidence to demonstrate if accidents, incidents, and safeguarding events were recognised, recorded or if action was taken where required.
● Staff and the management team did not always recognise when abuse occurred. One person posed a risk to others, including their intense focus on another person. For example, there had been incidents when the person had touched them and tried to give the other person drinks. In addition, there was an incident when the person demonstrated potentially sexualised behaviour to the other person. Although some of these incidents had been shared with the local authority safeguarding team, no action had been taken to ensure all people were protected from potential or actual abuse.
● One staff member when describing the person told us, "[Person's name] is a risk and I am frightened of them; I don't really know what to do, as they get aggressive when we intervene." Another staff member said, [Person's name] actions worry me, they can be very hard to manage." These risks had not been fully assessed and no guidance was in place, so staff would know how to support the person to reduce the likelihood of incidents occurring. There was no guidance for staff about how to support the person or protect others and no risk assessments in place. We discussed this with the registered manager and a senior manager for the provider and following our inspection appropriate risk assessments were completed. However, when we reviewed these risk assessments, there was insufficient information to guide staff how to keep people safe from harm.
● Staff were able to tell us what action they should take if they witnessed or suspected abuse. However, we found they did not always recognise incidents as abuse. CQC expect providers to provide training in line with best practice. The Social Care Institute of excellence (SCIE) recommend that all staff working in health and care settings complete safeguarding training annually. We found out of 43 staff who worked in the service, 9 had not received safeguarding training for over 2 years. This meant we could not be assured all staff would recognise abuse or take action when needed.
● The provider had a safeguarding policy in place. However, this had not always been followed. The policy states, "The registered manager must take steps to ensure that there is no further risk of the victim being abused/harmed by the alleged or suspected perpetrator." This had not always happened.

The failure to have systems in place to ensure people were protected from abuse and neglect was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● The provider assessed the level of care and support each person needed and adjusted their staffing levels

accordingly. However, we observed that due to the high needs of people living in the service and known risks, staff were not always available to be able to reduce the likelihood of incidents occurring. For example, we observed one person who posed a risk to others by their behaviours. Although staff engaged with the person and we witnessed one incident being prevented, staff were not always available and there was no plan in place to consider where staff were deployed to reduce the risks. We discussed this with the provider and registered manager, who agreed to review this and were engaging with external health professionals.

● The registered manager told us they did not complete audits of call bell response times. Although call bell times could be monitored by the management team each day, there was no overall oversight. This was important to be able to consider if staffing levels were meeting people's needs, or if there were areas of risk that required action to be taken. We reviewed call bell times over a 16-day period from the providers electronic system. During this period, we found people's call bells were not answered in a timely way. For example, we saw numerous examples over this time period where call bells were not answered for up to 3 hours. Although, it could have been possible the call bells were not making an auditory sound and were not being cancelled by staff when they attended people, the lack of oversight of this system meant any failings were not identified so that action could be taken. This placed people at risk of harm.

● External professionals also raised concerns with us about staffing availability and call bell response times. One external professional said, "I have noticed alarms being triggered and then being responded to and cancelled a considerable time later." Another said, "I have found that there is a lack of staff around the main lounge area, as they use CCTV to monitor the lounge and conservatory area. When I have visited, there have been no staff interactions with the residents [people] in the lounge or dining area."

● People and their relatives told us staff were not always available and they had to wait longer than expected for support when they pressed their call bell. Comments included, "Sometimes you feel you wait all day. They're [staff] good if you see someone, they'll help or go and get someone, but sometimes there's no one about", "There's lots of people here and sometimes there's not anyone [staff] in there [lounge]", "You have to wait sometimes. Sometimes you wait quite a long time" and "[There is] probably not [enough staff]. The staff would probably say there's not enough."

● Staff told us they were busy and at times it was hard to meet everyone's needs. One staff member said, "It can get really busy, and we have more people now who need 2 staff for the hoist and things, so it can all get a bit much, but we do ok."

The failure to ensure there were sufficient staff available to mitigate risks to people and safely meet their needs, was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

● Staff had been recruited in line with Schedule 3 of the Health and Social Care Act, as required. This meant recruitment checks had been completed to ensure that new staff employed were suitable to work at the service.

Using medicines safely

● Systems were in place to safely manage medicines. Senior care staff administered medicines and had received training to ensure safety was maintained. Staff competency checks were completed annually or if required in between, such as when medicine errors occurred.

● Protocols were in place for medicines which were given 'as and when required', (PRN), but we found some of these needed additional information adding. This was so staff would always understand when to give PRN medicines or if other actions should be taken before giving medicines, such as to manage agitation. We discussed this with the registered manager and deputy manager and this action had been taken by the second day of the inspection.

● Medicines that require additional legal measures were stored and administered safely. Body maps were

being used to ensure staff understood where to apply topical creams prescribed to people.

Preventing and controlling infection
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were able to have visitors to the home and were supported to maintain contact with relatives or friends as they chose. Safe processes were in place to facilitate this.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Staff had not received training or had not completed up to date training, to equip them in their role and enable them to meet people's need safely. For example, out of 22 staff who delivered direct care to people 14 had not had falls awareness training and 2 were overdue a refresher, 9 staff had not completed safeguarding training for 2 years or more, 8 staff had not completed pressure care and 1 required a refresher and 4 staff had not completed moving and handling training and 2 were overdue for a refresher. We discussed this with the provider and asked to see their training policy. The provider confirmed they did not have a training policy in place. This would be important to identify which training was mandatory for staff to complete, and the frequency of when this should be completed or refreshed.

● CQC expect providers to provide training in line with best practice. The Social Care Institute of excellence (SCIE) recommend that all staff working in health and care settings complete training in moving people safely, fire safety, safeguarding and behaviour management yearly. The National Institute for Health and Care Excellence (NICE), recommend medicines training is completed yearly. Following the concerns we raised about training, the provider shared with us their newly implemented training policy and further information about training staff had received. This also showed staff had not all received up to date training.

● Although staff were able to describe how they would support people safely in areas such as moving people safely, they were not confident in managing behaviours that posed a risk to people or others. Staff had not always safely managed risks, such as falls people had. This meant we were not assured staff had the skills and knowledge to safely meet people's needs.

● The provider had identified in their 2022 health and safety audit that some essential training was out of date, including moving and handling. However, although this was added to an action plan, which showed it was completed in September 2022, we found 9 staff had not completed this training since 2020 or 2021. This meant we could not be assured all staff had up to date moving and handling training to ensure people were safe when using equipment to move them.

The failure to ensure staff received appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had not all received regular supervision meetings and all staff except for 1, had not had an appraisal in the last year. This is important as it enables the management team to monitor and support them in their role. We discussed this with the provider who took immediate action to ensure staff would all be provided with regular support and guidance.

● Staff told us that they had received an induction when they started working in the home. This included shadowing more experienced staff, whilst getting to know the people living at the home.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff were able to describe a basic understanding of the principles of the MCA. For example, supporting people with day-to-day choices. However, people's rights were not always upheld and maintained in line with the MCA. For example, we found where two people who were sharing a bedroom, their human rights had not been fully considered. Both people lacked the capacity to consent to sharing a room and the MCA had not been used to make decisions based on each of their best interests. Following concerns raised about this, the management team discussed the arrangement with their families, and they were moved into their own individual rooms.
● Some people had a diagnosis with symptoms which meant they may lack capacity to make decisions about their care, or consent to restrictions in place, such as bed rails and falls prevention alarms. Mental capacity assessments had not always been completed, where appropriate, and decisions had been made without demonstrating these were in people's best interest. We discussed this with the registered manager and provider, who took action to review decisions being made and to ensure records were completed where required.
● A closed-circuit television (CCTV) system was in use in the communal areas of the home. Although some people who lacked capacity to consent to this had MCA assessments and best interest decisions recorded to consider the infringement on their privacy, this was not consistent. It is important that where CCTV is used in a care home, people's right to understand their use and the reasons why is considered. If people lack capacity to consent to this, their relatives should be consulted, and best interest decisions made. This is important to protect people's human rights.
● We were told some people had conditions on their DoLS to promote their rights. However, we were unable to find information what those conditions were within their care records. An external professional confirmed with us, "[Some people] have special conditions on their DoLS; for example, one [person] is supposed to have a record of all the times they have been offered access to the community and the outcomes of those offers. I have no evidence that this record is being kept." We asked the management team about conditions on people's DoLS, and they were unable to clarify who the people were and what the conditions in place were. Therefore, we could not be assured these conditions were being met. The provider assured us they would review this and ensure they understood the legal requirements in place.

The failure to consistently put in to practice all the requirements of the MCA was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before they moved into the home. Care plans were developed and recognised tools were used to assess people's level of risk of skin damage, malnutrition and oral health needs. However, we found that these tools and information within care plans was not consistent. This is important to ensure staff have all the information they need to support people safely. More information about this is described in the safe and well-led section of the report.

● An action plan had been completed by the provider in November 2022, which identified areas for improvement in people's care plans, to be completed by 30 April 2023. Although, 14 people's care plans were identified as having been improved in April and May 2023, we found essential information was still missing or not consistent throughout people's care plans. For example, one person's care plan described how they moved with a walking frame and two staff supporting them. However, in another part of their care plan it described they needed a hoist for all transfers and were unable to weight bear. This meant assessments were not consistently being updated to ensure information was clear and accurate throughout people's care records. We discussed this with the provider who assured us all assessments and care records would be reviewed.

Supporting people to eat and drink enough to maintain a balanced diet

● Where people required a specific diet or food and drink of a different consistency, information in their care plans was not sufficiently detailed or was not in place. This was important so staff would understand their needs and any associated risks. We discussed this with the registered manager and provider who told us they would take immediate action to ensure the required information was in place.

● The service employed a chef who prepared freshly cooked food. There was a menu in place and people had been involved in choosing the meals they wished to eat. In addition, food people liked or disliked was recorded in their care plans.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Peoples care records did not always contain consistent detailed and clear information for staff on how to best support people with their health conditions. However, when we discussed people's needs with staff and management team, they were able to demonstrate they understood people's basic health needs. An external health professional told us, "Care staff are escalating any concerns in a timely fashion to request any advice, as we visit daily."

● People were supported to access healthcare services when needed. Records confirmed that people were seen when needed by doctors, nurses and chiropodists.

● The electronic care records system in use enabled a summary of essential information to be printed out if people were required to move between services, such as requiring a hospital stay. However, as described in the safe part of this report, information about risks were not always completed or sufficiently detailed to enable safe care to be provided.

Adapting service, design, decoration to meet people's needs

● The service was clean and decorated throughout.

● Floors could be accessed by a lift and stairwells. Flooring was suitable for people with mobility needs and to enable appropriate levels of cleanliness to be maintained.

● People's rooms were furnished and adapted to meet their individual needs and preferences. Pictures and soft furnishings evidenced people, or their relatives, were involved in adapting their rooms.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect. Staff did not have all the information they needed to ensure people could be cared for in line with their wishes.

Respecting and promoting people's privacy, dignity and independence

● People were not always treated with dignity and respect. On the first day of our inspection, we observed two people who shared a room. Both were cared for in bed and the curtains were only partially open, meaning the room was in semi-darkness during the day. One person's bed faced the window. We asked staff why the curtains were drawn and if both people needed the room darker. A staff member told us, "If we don't have the curtains drawn, the sun goes in their [person facing window] face." No consideration had been given to the impact on either person, spending all of their day in semi-darkness. Both people had televisions which had the same channel playing. When we asked if they both wanted to watch the same programme, it was clear no consideration had been given to this. Neither of the people had the capacity or verbal communication to be able to raise concerns. No consideration had been given to what was in each of their best interests.

● During lunchtime on the first day of our inspection, we observed a staff member bring two plates of food to the two people sharing a room and cared for in bed, who both required support with eating. They sat next to one person supporting them, whilst the other person's meal was left going cold. This was undignified and showed a lack of care and consideration for each person's needs or wishes.

● We discussed the two people sharing a room with the registered manager. We asked if there was any screens or curtains in use to protect each person's dignity during personal care. The registered manager confirmed there were not. This meant people's privacy and dignity had not been considered.

● Another person needed their drinks thickened so they could safely swallow. They had drinks in a cup with a lid and spout to support them to be able to drink independently. We observed the person had three cups on the table in their bedroom which had been left near them and were half empty. This meant when staff brought the person a fresh drink, they failed to remove the old one, which demonstrated a lack of care and consideration.

● We used our short observational framework inspection [SOFI] tool, to assess staff engagement with people. During our observations, although staff did speak to those people who were vocal, they did not consistently engage people who were living with dementia and had no or limited verbal communication. For example, two people who were living with dementia and had minimal ability to communicate with staff were sat with other people in the lounge on the second day of our inspection. We observed people and staff using our SOFI for 45 minutes. Despite 4 staff present, who were supporting people to their seats, none of them spoke to the two people who were disengaged. We observed them sitting staring with a blank expression for the whole 45 minutes. This meant people did not aways receive positive, caring communication from staff. In addition, an external professional described to us how, "My colleague

witnessed two staff talking 'over' a resident [person], rather than talking with them and engaging them in the conversation."

● People were not always consulted before staff did things to them, or for them. For example, when people were sat in the dining room at lunchtime, we observed some people were provided with clothes protectors. Staff did not ask them if they wanted them or explain they were putting them on. One staff member approached a person and said, "Let's have this on you," whilst placing the clothes protector round their neck. Another person who ate in their room and had been provided with a clothes protector, told us, "I hate wearing one".

● In addition, we saw a person was sat near a table in a wheelchair at lunchtime. Two members of staff spoke to each other to say the person shouldn't be left there, as the wheelchair would obstruct others. One of the staff then moved the person to another table, without speaking to them or telling them what they were doing and why. This meant we could not be assured people were treated with dignity and respect. We discussed this with the registered manager and provider's senior manager who gave assurances they would look into these concerns.

The failure to ensure people were treated with dignity, respect and privacy, was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

● We observed staff treating people with kindness when they spoke to them. However, staff did not always engage people in meaningful conversation.

● When staff did engage with people and their relatives, we saw this was positive, kind and caring. One staff member walked into the lounge with a big smile on their face and spoke to some people saying, "Hello my lovely, how are you today, you look lovely." During the lunchtime period one person was distressed and asking the same repeated question. Staff attempted to distract them and appeared concerned about them. Another person became upset, and a staff member sat beside them and listened to them, whilst holding their hand.

● Relatives told us they felt staff knew people and were kind and caring. One relative said, "I can't fault the staff, they really care and always make me feel welcome. The [registered] manager also clearly cares and will speak to me if I need any assurance." Another relative said, "I can't think of anything that would improve it [the home]. I'm really, really happy. If my [relative's] upset, they [staff] all hurry to reassure her."

Supporting people to express their views and be involved in making decisions about their care

● People's care plans demonstrated they had been asked their views and wishes. However, information was not consistently updated and as described in the effective part of the report and above, consent was not always sought. This meant we could not be assured that information about people's individual needs and wishes was accurate and up to date.

● Staff told us they offered people choices and encouraged them to be involved in decisions about their care and support. One staff member told us, "We always ask people what they want and try to give them a couple of options, to make it easier for them to make a choice." However, our observations showed this was not consistently implemented by all staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were not always up to date or fully completed. This meant staff, including staff who may not know people well, such as new staff or agency staff, may not have all the information they needed to deliver person-centred care.
- Although people's care plans did contain some person-centred information, this did not always reflect an up to date, contemporaneous record of people's individual and diverse needs and wishes. For example, where people had complex needs there was insufficient information to describe how they may present and what action staff should take to provide person centred care.
- People had needs in relation to their mobility, skin integrity, nutritional needs, end of life care and anxiety or agitation. Information about these needs lacked detail or was not completed within their care plans. This meant staff would not always understand how to find the information they needed to support people.
- When care plans had been reviewed, inconsistent or out of date information was not identified and corrected. This meant reviews were not effective and led to people being put at risk of harm, and receiving care which did not meet their needs. We discussed this with the provider who assured us they would review all people's care plans to ensure information was consistent, up to date and captured people's individual wishes. More information about the associated risks is detailed in the safe section of this report.
- People and their relatives told us they were happy with the service provided and felt staff knew people well and were friendly and approachable. One person said, "It's [the home] friendly, efficient and well run." A relative said, "All the important things are there. All the staff, not just one or two, go out of their way with all the residents [people]. No one is left out. They [staff] are kind and reassuring to everyone."

End of life care and support

- Although no people were receiving end of life care, some people were on the end-of-life care pathway due to a deterioration in their health and frailty.
- Although people's care plans contained some information such as their religion and where they wished to be at the end of their life, such as at Magnolia House, there was insufficient detail about people's individual and specific end of life wishes. For example, information recorded was not person centred, such as describing specific music the person may like, which family members they wanted there, or what type of funeral they would want and at which location. One person's care plan said, 'After death- For my final wishes to be met.' Another person's said, 'I would like my need to be discussed with me nearer the time.' This person had a diagnosis of dementia and as time passed, would be less likely to be able to express their wishes. This meant there was a risk people's needs and wishes would not be met at the end of their life.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

● Although an activities member of staff was employed, records showed meaningful activities to meet people's social needs and provide mental stimulation were not regularly being provided. We reviewed activity records for people during the month of April and May 2023. Although people were supported to watch television, read and receive visitors, there was a lack of consistent or varied activities provided.

● Organised activities, such as arts and crafts, singing or gardening, were not regular and not all residents wanted to or were able to engage in these activities. For example, during May 2023 records showed only 3 occasions where planned activities were provided. During April 2023 only 2 occasions when activities took place. We discussed this with the provider who did provide some further evidence of activities such as celebrating the Kings Coronation and people's birthdays. However, regular meaningful activities and engagement with people to ensure they had a good quality of life needed further improvement.

● External professionals also described people not being supported with meaningful activity. One said, "I have not seen staff interactions in the lounge area, or any activities being undertaken either."

● People were supported to maintain friendships and important relationships. We saw relatives visiting people throughout our inspection. One relative told us, "I come in every week, and they [staff] let me know if my [relative] needs anything or if there are any changes, I need to be aware of. I feel welcome and get to spend time with my [relative]."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were identified within their care plans. For example, one person's care plan described they spoke softly, so staff may struggle to hear them, and they needed time to process information, so they could consider their response. There was a description of how staff should meet their need such as, 'staff to avoid noise pollution such as the television or radio in the background.' This meant staff were supported to understand people's communication needs.

● Picture cards were available for people if needed, to assist them to make choices for meals.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and process in place which was available to people, relatives and visitors. We reviewed complaints records and could see these were investigated and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a lack of oversight in respect to the quality of care provided. The provider and registered manager did not have systems in place to identify and address all the areas of concern identified in this inspection. Where areas for improvement were identified, action had not been taken to address these in a timely way.
- Care plans, mental capacity assessments and risk assessments lacked information or had not been completed. Where they were in place, they did not reflect the care and support people required. Risks identified, contained insufficient or no information to guide staff on how to manage these. The lack of information put people at risk of receiving inconsistent care and support. Although the provider had identified some of these areas for improvement, they had not identified all the failings we found. They had not ensured improvements were made in a timely way. This was important to reduce the ongoing risks to people.
- Policies were not always accessible to staff or had not been followed. For example, the safeguarding policy had not been followed by the management team or staff in identifying, reporting and managing safeguarding concerns to keep people safe. Furthermore, at the start of our inspection the provider did not have a training policy in place. Following our inspection, a training policy was implemented.
- The registered manager had failed to ensure all accidents and incidents were monitored, reviewed and action was taken to reduce the ongoing risks of harm.
- Although the provider had systems in place to monitor and review safety and the care people received, these had not always been implemented effectively. This meant, where there were areas of care that required action and improvement, such as call bells being answered, or head injury monitoring being recorded, these had either not been identified or action was not taken when needed. This led to people being put at significant risk of harm.
- Information about people's needs was shared at handovers between each shift. However, this was not consistent and essential information was not always shared. For example, when people had unwitnessed falls, this was not always clearly shared to ensure any head monitoring was taking place and being recorded.

The failure to maintain up to date and accurate records related to people, to assess and monitor the service, mitigate risks and improve the quality and safety of the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The Health and Social Care Act 2008 requires that registered persons of all care services notify the

commission of significant events. This is so we can monitor if appropriate action has been taken to support people when injury or abuse occurs or is suspected. We identified 3 incidents and 5 safeguarding events that the registered manager and provider had failed to notify the commission of.

The failure to notify the commission of significant event was a breach of Regulation 18 notification of other incidents, Care Quality Commission (Registration) Regulations 2009

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The views of people, staff and visiting health and social care professionals had not been sought through formal feedback, meetings, or surveys. The registered manager told us they spoke individually to people and their relatives but did not record these conversations. When feedback from relatives had been sought, there was no evidence this had been received, analysed or action taken if required, to ensure people were receiving a consistently good service. We discussed this with the provider who told us they encouraged relatives and professionals to give feedback through a national website for care home reviews. However, this meant we were not assured there were robust systems in place to capture people's lived experiences and to seek and act on feedback from others.

● People who live with dementia and cognitive impairments cannot always express their views. Their lived experiences were not being captured, considered, or analysed to ensure they were receiving good quality care.

● Some staff had experienced discrimination, from people they supported, who may have been living with a cognitive impairment, which had not been recognised or acted upon by the whole staff team. Although the provider had an 'Equality, Diversity and Inclusion Policy', guidance was not in place for staff to address any discriminatory behaviour in a safe and respectful way. We discussed this with the provider who took immediate action to support staff and improve the culture.

● Staff told us they sometimes felt supported, but in other areas they felt they had to "just get on with it". One staff member, when describing experiencing racial verbal abuse they had received, told us, "There is nothing anyone can do, they [management team] just say they [people] can't help it." We discussed this with the registered manager and provider's senior manager who told us they would review the situation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Improvements were needed to the culture of the service. Whilst staff were individually caring and when they spoke to people, were kind and considerate, we found there was a task centred culture in the service. We observed staff did not always treat people with dignity.

● People and relatives told us they thought the service was well-led. Their comments included, "I suppose I do [think it is well-led], as far as I'm concerned", "Yes. They [management] would listen, if anything cropped up", and "Anything can be improved, but it's adequate here for what you need." However, this was not apparent from the evidence gathered through this inspection. These findings are referred to throughout this report.

Continuous learning and improving care; Working in partnership with others

● The registered manager told us they worked well with local health professionals. However, as described above and in the safe section of this report, records of any monitoring or changes to people's needs were not always recorded in people's care plans. This meant we were not assured that the management team always acted on advice and guidance from external medical professionals.

● We saw evidence of engagement with other external professionals including social workers, GPs and nurses.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider applied the duty of candour following incidents in the service when they had been made aware of them. We saw evidence of one incident, where duty of candour had been used. However, we found other incidents which had not been reviewed and shared with the provider to ensure action was always taken where needed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the commission of significant events.

The enforcement action we took:

We have placed a condition on the provider's registration to ensure they have reviewed all accidents and incidents and notify the commission where legally required to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registeerd manager and provider failed to ensure people were treated with dignity, respect and their privacy was upheld.

The enforcement action we took:

We have placed a condition on the provider's registration to ensure they have reviewed all people's care plans and staff have received adequate training and support to meet this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registeerd persons had failed to consistently put in to practice all the requirements of the MCA

The enforcement action we took:

We have placed a condition on the provider's registration to ensure they have reviewed people's care plans, MCA and best interests records are made where required and staff have received adequate training and support to meet this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed. They had also failed to investigate and review risks arising

from incidents that had occurred and to reduce the likelihood of a reoccurrence.

The enforcement action we took:

We have placed a condition on the provider's registration to ensure they have reviewed alll people's care plans, completed risk assessments where required and reviewed all accidents and incidents. They must ensure all staff have received adequate training and support to meet this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons failed to have systems in place to ensure people were protected from abuse and neglect .

The enforcement action we took:

We have placed a condition on the provider's registration to ensure they have reviewed all accidents and incidents and have taken action where needed, to stop or reduce the liklihood of abuse occuring. They must ensure all staff have received adequate training and support to meet this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to ensure each person had an accurate, complete and up to date care plan and to assess and monitor the service, mitigate risks and improve the quality and safety of the service.

The enforcement action we took:

We have placed a condition on the providers registration to ensure they have reviewed all people's care plans and that information contained within is accurate and refelective of people s individual needs and wishes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had to failed to ensure there were sufficient staff available to mitigate risks to people and safely meet their needs and that systems in place for people to request assistance from staff were effectively working.

The enforcement action we took:

We have placed a condition on the provider's registration to ensure they have reviewed all people's care plans and that information contained within is accurate and reflective of people s individual needs and wishes.