Magdalen House Limited

Magdalen House Care Home

Inspection report

Magdalen Road
Hadliegh
Ipswich
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Tel: 01473829411

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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 on 1 March and was unannounced. The service provides accommodation and personal care for up to 53 people some of whom are living with dementia. On the day of our inspection 52 people were using the service.

The service has 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 2008 and associated Regulations about how the service is run.

At our last inspection of 09 June 2016, we found there were not always enough staff to meet the assessed needs of the people using the service. An action plan was sent to us by the service of how this would be addressed. At this inspection, we found that there sufficient numbers of staff to meet the needs of the people using the service.

People were protected from the risk of abuse as staff had attended training to provide them with knowledge and an understanding of their roles and responsibilities with guidance in how to respond if they suspected abuse was happening. The manager had shared information with the local safeguarding authority when needed and the service had a safeguarding policy and procedure.

The manager had ensured appropriate recruitment checks had been carried out on staff before they commenced work to determine they were suitable to work with the people living at the service. Emphasis was placed on providing care and support in ways that people preferred as part of the interview process. Staff were supported through staff meetings and regular supervision and relevant training sessions.

The provider had systems in place to manage medicines and people were supported to take their prescribed medicines safely.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Appropriate mental capacity assessments and best interest decisions had been undertaken by relevant professionals. This ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice. MCA, Safeguards and Codes of Practice are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals. People at the service were subject to DoLS. Staff had been trained and had a good understanding of the requirements of the Mental Capacity Act 2005 and DoLS.

People's health needs were managed appropriately with input from relevant health care professionals. People were treated with kindness and respect by staff who knew them well. People were supported to maintain a nutritionally balanced diet and sufficient fluid intake to maintain good health. Staff ensured that people's health needs were effectively monitored. The staff were aware of individual health needs and

responded to people's concerns and behaviours in an appropriate and compassionate manner.

Positive and caring relationships had been developed between people and staff. People were supported to make day to day decisions and were treated with dignity and respect at all times. People were given choices in their daily routines and their privacy and dignity was respected. People were supported and enabled to be as independent as possible in all aspects of their lives.

Staff knew people well and were trained, skilled and competent in meeting people's needs. Staff were supported and supervised in their roles. People, where able, were involved in the planning and reviewing of their care and support.

People were supported to maintain relationships with friends and family so that they were not socially isolated. There was an open culture and staff were supported to provide care that was centred upon the individual. The manager and deputy were approachable and enabled people who used the service to express their views.

There was adequate planning in place for most people using the service. However we found that people newly admitted to the service did not have their needs assessments developed into a care plan.

People were supported to report any concerns or complaints and they felt they would be taken seriously. People who used the service, or their representatives, were encouraged to be involved in decisions about the service.

The provider had systems in place to check the quality of the service and take the views and concerns of people and their relatives into account to make improvements to 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?

Good

The service was safe.

The service identified and reduced risks through carrying out and implementing the actions of risk assessments.

Staff had completed training and on-going training was planned in the safeguarding of vulnerable adults. Staff knew the different types of abuse and how to report concerns.

The service had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service.

The service had procedures in place for managing people's medicines.

Is the service effective?

Good

The service was effective.

Staff were supported to provide care to people who used the service through supervision and annual appraisals.

The manager understood and had implemented appropriate actions regarding the Mental Capacity Act 2005.

People had access to food and drink throughout the day and staff supported people when required.

People's health was monitored by the staff and there was access to healthcare professionals.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People who used the service and their relatives were involved in developing and reviewing care plans and assessments.

People's rooms were individualised with people's own furniture and personal possessions.

Is the service responsive?

Good

The service was responsive.

Staff were aware of people's needs from assessments and individualised care plans were developed from the assessments.

There was a range of activities organised for the people using the service

The provider had a complaints procedure in place and people told us they knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The provider had a quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff considered they could approach the manager for support and advice.

There were staff meetings and sufficient time for handovers between shifts for the staff to be aware of the changes in people's conditions.

Magdalen House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 March 2017 and was unannounced.

The membership of the inspection team was four inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their specific area of experience is with older people and dementia care.

Prior to the inspection we gathered and reviewed information about the service including notifications. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made judgements in this report.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted two healthcare professionals who provided support to some of the people that use this service.

The methods that were used during this inspection included talking to people using the service, their relatives, interviewing staff, pathway tracking, observations and reviewing records. We also 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.

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We spoke with eight people who used the service and four relatives, the registered manager, acting deputy, administrator, activities person and six other members of the care staff. We look at three staff files, eight medicine records and eight care plans.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "The staff are always there if you want them, you've only got to ring the bell and they are here". A relative told us, "We know where [my relative] is and that she is safe."

The service had sufficient equipment in place to meet people's individual needs including hoists, pressure mattresses, wheelchairs and walking frames. The slings, hoists and the passenger lift had been inspected in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). The service carried out weekly fire tests and there were emergency plans in place which would be implemented in the case of any emergency.

The manager analysed accidents and incidents including any falls that people experienced to learn any lessons from the situations. We saw that the service had involved appropriately other professionals for advice regarding falls and also when people presented with distressed behaviour in response to situations or others. A member of staff told us about how they recognised when someone became anxious or distressed and the actions they took to prevent the behaviour becoming increasing challenging which helped to keep the person safe from harm.

The deputy manager told us about the policies and procedures in place to ensure prospective staff had the appropriate character and background for the role. These included obtaining written references and a criminal records check with the disclosure and barring service.

A member of staff told us about the safeguarding training they had received and their understanding how to keep people safe. They were aware of how to report any allegations of abuse and protect people from the risk of abuse. The deputy manager and a member of staff told us how to implement the correct procedure for informing the local authority, contacting relevant healthcare professionals and notifying CQC. Staff had completed training in the safeguarding of vulnerable adults.

In order to prepare for emergencies it is important that the service has personal emergency evacuation plans (PEEP)'s in place for each person. The plans we saw were detailed, person centred and included useful information such as 'has a relaxant medication so may take longer to wake'. We saw assessments were in place for people who required support to mobilise. Control measures for risks were sufficiently detailed to include specific information on equipment such as hoists, for example, sling sizes, number of sling and kind of sling.

People's care plans contained information about the use of pressure relieving equipment and we saw that this was in place for those people requiring this support.

Regarding the care of one person the staff had identified they were at risk of falling in the night and with their and their families permission had installed a sensor mat into the person's room. The purpose of this is to alert the staff should the person get up during the night so that they could offer assistance.
The management team reviewed the falls diary and sought the support of other professional services to

advise them of any action to take in order to try to prevent further falls happening.

The service had a robust recruitment process in place. We saw that potential new staff were required to complete an application form and any gaps in employment history were covered at interview. The deputy manager told us about the policies and procedures in place to ensure prospective staff had the appropriate character and background for the role. These included obtaining written references and a criminal records check with the disclosure and barring service. Each member of staff was given a job contract and job description so that they were clear regarding their responsibilities.

To ensure there were sufficient staff on duty to meet the needs of the people using the service each person's needs were assessed and then staffing numbers including senior and management staff were calculated. The manager told us that the service was overstaffed by ten percent to take account of not being able to cover any staff sickness at short notice. We examined the rota and this matched with the numbers staff on duty on the day of our inspection. People using the service told us, as did the relatives that we spoke with, that there were sufficient staff on duty at all times. This was the view of most of the staff we spoke with, although one member of staff did say that the service could drop to three staff at night which would clearly be insufficient. We spoke with a member of care staff and deputy manager after the visit to gauge the night staffing situation and on each occasion we were told there were five staff on duty. The manager had arranged for a twilight shift which meant one member of staff working to midnight so that this member of staff was available to help people during the busier times of the day and in particular helping people to retire for the night.

People's medicines were managed safely. There was a policy and procedure for the administration of medicines. During our inspection we saw staff approach people to ask if they required any pain relief.

The medication administration records (MAR) charts we saw were clear, with no gaps in the record and highlighted issues such as swallowing difficulties. They also covered allergies and any medical attentions of which to be aware such as diabetes. There were specific protocols in place for the use of medicines such as Glycerol Triturate (GTN), a spray used to relieve angina. Staff told us about medicines which needed to be given before food, such as Lansoprazole, and that this was given by the night staff in order that sufficient time passed before the person had their breakfast. The pharmacist delivered medicines training every three to six months for the staff assigned to administer medicines and refreshed competencies as required.

The remaining numbers of medicines matched with the (MAR)'s. During the medicine round we observed we saw the member of staff being patient and taking their time with each person to answer any questions the person had.

Good

Is the service effective?

Our findings

The manager rotated staff so they were familiar with the whole service and not just a specific unit. This commenced when the new member of staff started working at the service so that they were supported to become familiar with the whole service.

The manager told us the key challenges for the service were increasing the uptake of training for its staff which they said they had done. They said staff got paid to attend which encouraged attendance. There was a lot of training booked which included: dignity in care, pressure care, first aid and end of life care for seniors. Some staff including the manager had train the trainer qualifications so they could provide in house training. Staff all received dementia training. The manager told us all staff were either signed up to do further training or had completed training up to NVQ 3.

Staff were supported through regular staff meetings, supervision and an annual appraisal. An annual appraisal is a one to one meeting between the manager and member of staff to discuss the achievements over the past year and set objectives for the staff development in the next year. A member of staff told us, "I am happy with the training provided." Another member of staff told us that they would like to know more about diabetes but were confident the manager would arrange additional training in this and other physical health related subjects.

A new member of staff was provided with an induction which was monitored during the first three months of their time at the service and was signed off by themselves and the manager at the time of completion. The induction involved shadowing which is when the new staff member worked alongside an existing experienced member of staff for support for during their first few weeks, prior to being allowed to work on their own. During this time the new member of staff was not counted on the rota. A member of staff told us, "I recall my own induction quite some time ago and now I am happy to and a new member of staff will shadow me for support during their induction training."

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.

People can only be deprived of their liberty so that they can 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at records and discussed the DoLS with the manager, who told us that there were DoLS in place

as well as some in the process of being applied for. They told us why the DoLS were required and how the service had worked with the person and families to explain the situation and plan the management of care. In some cases the manager had arranged for a best interest meeting to be held with the person, their families and other professionals to determine how care was to be provided and these meetings were recorded. We looked at the documentation and saw that the service was following the requirements in the DoLS.

People's nutritional needs were being met. Most people liked to use the dining room at meal times which was presented with place mats and various condiments. Some people liked to stay in their rooms sometimes for meals while others preferred to remain in the lounge and their choice was respected by the staff. People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining room at lunch time when required. At lunchtime we observed staff supporting people with care and empathy. We observed staff chatting with people who used the service. The atmosphere was relaxed and unrushed. We looked at records and spoke with the cook who told us about people's special dietary needs and preferences. One person told us about the meals that were served throughout the day they said, "Very nice indeed."

Food was prepared in the kitchen and looked appetising and hot. People chose from a standard rotating menu, with the days dishes illustrated with a colour photograph of what the meal would look like. Relatives told us this was an efficient and effective way of allowing people to make a meal selection.

We saw that when other professionals visited the service they had written in the notes the support they provided and guidance for the staff to be carried out to support people. We saw evidence of visits by healthcare professionals including General Practitioner, speech and language therapy (SALT), dentist, optician, dietician, chiropodist and district nurses. This meant the service ensured people's healthcare needs were considered, monitored and met. People and their relatives spoken with felt that their needs were well met and catered for. Local services such as doctors, hairdressers and chiropodist all made regular visits to the home.

Staff told us they worked well with their local GP practice and had an excellent relationship with the district nurses who they said provided training, advice and practical support. The nurse practitioner also visited weekly. They said they liaised with the local hospice and again some training was provided.

Good

Is the service caring?

Our findings

The staff had developed positive caring relationships with the people using the service and their relatives. One relative told us, "It is marvellous the way they have cared for [my relative], they have kept us informed of all events and we are made very welcome when we come to visit."

The service was divided into separate areas with regard to the assessed needs of the person. In order to maintain the caring relationship to meet the person's assessed needs one person was moving from one area to another where the staff could focus upon their increased dementia needs. A member of staff informed us that it was very upsetting to see a person's needs increase but they were pleased that the service could continue to provide the care the person required which had been agreed with them and their family. Some staff worked across the different units of the service and hence the move from one unit to the other would be eased by the person knowing some of the staff.

Staff told us they often attended funerals of people who had used the service as a mark of respect and were planting a rose in memory of a person who recently passed away.

People were treated with dignity and respect. We saw staff communicating with people in various ways including hand gestures as well as talking to people in a polite and respectful manner. Prior to any care being provided we saw that staff approached the person from the front so that they could easily recognise them and gained their consent before providing any care. One person told us, "It's nice here, because there are some very nice staff."

We observed staff interacting with people in a caring manner and supporting people to maintain their independence with mobility and making decisions about what they wanted to do. We saw staff knocking before entering people's rooms and closing bedroom and bathroom doors before delivering personal care.

The staff had listened to people's views and discussed them with them. People's bedrooms were individualised with their own furniture and personal possessions. We looked at daily records, which showed staff had involved people who used the service and their relatives in developing and reviewing care plans and assessments. The people who used the service told us they knew about their care plans. Relatives we spoke with were aware of their relatives care plans. The service did have group meetings with people and also relatives. Each person was involved in a review of their care plan at regular set times and as required with the manager and their relatives.

The manager told us that they would involve advocates if the need arose to support people. A member of staff told us about the ways in which people's confidentiality was maintained. They spoke about how information about people would only be shared with other people who had the right to know it. They explained that shift handovers were conducted in private out of earshot. This enabled sensitive information to be handed over on a need to know basis.

A relative told us, "I'm very impressed, [my relatives] care has been excellent, it's a lovely place, light and

airy, seems well staffed."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We spoke with an activities member of staff and they told us that they worked to a plan but this was flexible and they responded to people's feelings at the time. We saw people playing dominos and there was music playing of the people's choice. Staff checked that the volume was correct with people in the room at the time. Other people were knitting and in the afternoon people were consulted about a choice of which film to watch. The staff were encouraging people to set up a pen pal scheme with another of the provider's services. From talking with the staff it was apparent that for people that had been at the service for sometime the staff knew them well. One person told us, "The staff know me well and I am very happy here." This was confirmed by visiting relatives, one relative told us, "the staff keep us informed about [my relative] care, we are always made welcome by the staff whenever we visit."

The manager said there were three staff members providing activities and this was scheduled around people's needs. They told us a male member of staff was particularly good at engaging the men who lived at the home who would otherwise not leave their rooms. The manager told us some people attended different events and the service was part of dementia alliance who shared good practice amongst its members and ran different schemes in the community

We reviewed people's records and found these were of a variable standard. People that had been at the service for over a month had an individualised care plan. One record did not show us what continuous actions staff had taken. A person had been seen by the GP and had been prescribed antibiotics, it was not possible to see what additional care the person had received and if the antibiotic therapy was successful. However the staff were aware of this information that had not been recorded and therefore this has a minimal impact upon the person's well-being.

A number of people had an initial assessment of their needs but this did not show in any great depth what the persons needs were, the reasons why residential care was required or what the persons wishes and aspirations were or that of their families. The assessment was more of a checklist and therefore not personalised. For the people we case tracked some did not have life histories or information about their experiences which might have helped staff to relate to them and help them stay connected with things that were important to them. People moving into the service two or three weeks earlier still did not have care plans in place and staff only had the initial assessments to refer to.

The plan as explained by the manager was to write an individualised care program after a month to take account of the initial assessment and on-going assessments as the person settled into the service. We were confident from our discussion with the manager senior staff and care staff that the staff knew people's needs from the initial assessment and were responsive to their needs on a daily basis. This information was captured and written into the persons care plan. From our discussion of the length of time to write a care plan the manager informed us that this would be brought forward to two weeks from the time the person entered the service.
Care plans were reviewed on a monthly basis or more regularly should the need arise.

The service had a complaints procedure and this was visible in the service. People were given a service user guide which documented the service they could expect to receive and what they could do if it did not meet their expectations, including management and regional contacts. The manager said there had not been any complaints about the service since they came into post. They said they tried to give people every opportunity to raise issues about the service as they arose so they could address them as soon as possible. They told us about equipment they had purchased as a result of feedback they had received.

Good

Is the service well-led?

Our findings

The service has a registered manager in post. They had relevant care experience and was a qualified nurse. They were supported by a deputy manager and senior staff who were able to demonstrate good knowledge of care, relevant legislation and an understanding of the needs of people using the service.

The manager responded quickly to concerns. We brought to the attention of the manager a lock that was required to an electrical cupboard. At the time of our inspection the service maintenance was being covered by another service. It was not possible for the covering service staff to fit the lock, but the manager did arrange for a locksmith to attend to the service and carryout the work within 24 hours.

Staff felt well supported by the manager and said they were visible at the service and always approachable. The manager said they did not work at weekends but the deputy manager did. However, the manager said they were always on call but the out of hours on call was rotated and carried by the seniors so there was always additional support for care staff.

The manager said they carried out a monthly audit at a weekend just to ensure the service was being managed effectively in their absence. They told us about the improvements they had been making since their employment. They said their first priority was to provide some stability to the service. They had increased the staffing levels and had added an extra shift, a twilight shift from 6pm to 11 pm when staff had reported they needed additional staff.

The manager said they sought to reward good staff practice and had tried to encourage best practice through regular staff support. Formal support was scheduled for the year and included direct observations of practice. Staff also had annual appraisals. In addition, the manager said they led by example and would help out with people's care needs as required. They said they would not ask staff to do anything they wouldn't do themselves. They said they recognised the benefits of praising staff for their hard work and sharing any compliments received from relatives with them. We found a motivated workforce and felt certain this open, positive approach helped to make staff feel respected and valued. Staff had been given bonuses and treated to a Christmas party.

The manager talked about team work and the support they received from the staff, senior staff and the owners of the service. They said there were effective systems in place to ensure the service they were providing was both well planned and met people's needs. They told us they welcomed people's feedback and used it to improve the service where required and ensure the service was driven by people's needs and wishes. The manager had started to hold resident/relative meetings, which were recorded. This was taking a while to get established with low attendance but they felt this was because they had an open door policy and lots of families would raise issues as and when necessary. They had also started to collate letters and compliments received. We spoke to the manager about having a newsletter and pulling together a correspondence list of all relatives who could then be copied in to the newsletter, the meeting agenda and minutes. This was to keep relatives informed about the service. The manager told us they were soon to be sending out surveys to ask people and their relatives and visitors formally about the service they receive.

This was part of the overarching quality assurance system which would help inform the manager what they were doing well and where they needed to improve.

The service had a statement of purpose and this included building links with and being part of the local community. An adopt a friend scheme had been developed with the local school with the benefits of dementia awareness for the pupils who came with their teachers and played games or chatted with the people using the service. The school donated a shoe box of gifts to each person at the service once per year. The service had received a letter of thanks from the Ipswich hospital baby unit in recognition for the blankets that the people using the service had made and donated to the hospital.

Risks to people's safety were well managed. Incident/accident forms were collated and reviewed so incidents could be learned from.

The service also judged the safety and effectiveness of the service by carrying out regular audits of care. Some involved the analysis of data in relations to accidents, incidents, near misses and falls. By collating and analysing this information it was possible to identify themes and trends. This enabled the service to judge the effectiveness of their risk assessments and ensure actions taken were appropriate to people's needs and following an incident to review that everything they should have been in place was.

In addition the service carried out records audits and more qualitative audits of care such as dining room audits to ensure people were supported to eat and drink sufficient to their needs and to ensure the ambiance in the dining room was appropriate. The manager told us they had also completed night audits to ensure people were receiving continuity of care. The provider also did audits and had oversight of the audits completed by the manager. The manager completed weekly and monthly returns which included information relevant to the service and any risks or things that could affect the service such as maintenance issues or staffing issues.

We discussed the audits with the manager as we found that these did not necessarily identify the issues we did as part of our inspection. Gaps in care plans and people's records not being updated had not been identified. We also found the audits were not sufficiently in-depth or focussing on the persons lived experience. For example, the dining room audits focused on cleanliness, how well laid the tables were the ambiance rather than reporting on people's first hand experiences. We felt the service might need to adapt its auditing tools so they could be used more effectively. Some people were not able to tell us about their experiences but we saw through our observations that people were experiencing good care. Since the last inspection the service had introduced regular call bells audits as this was a concern we highlighted. We found this had brought positive results with calls bells being answered within several minutes.

The service was inclusive. The reception area was staffed which meant visitors were greeted as they arrived. There was lots of information to help people and their visitors to know what was going on at the service. The manager told us there were no volunteers currently but they had a number of students coming in from the local college as part of their placement and they were also planning to have secondary school children with the view of them spending time with people chatting and sharing interests and hobbies. They told us the local church visited and the local pub was frequented by some people using the service. The head of care said they had completed Dementia Friends training which is an initiative run by the Alzheimer's Society. They provide support and training but in return expect people receiving the training to provide training to other community groups to help promote dementia awareness in their communities. The head of care said it was a dementia friendly town which was welcoming of its visitors and they went above to engage and invite members of the community to visit the home. This included having open days and fetes.

The manager said the service was almost full and this was through word of mouth. They said other health care professionals had been recommending their service. Some people came into the day centre initially and then for respite care or longer stays. They said they had a few enquiries for potential volunteers. Trips out were possible but the service did not have its own transport but relied mainly on family although care staff would assist people to go out as far as possible.