Barchester Healthcare Homes Limited

Magnolia Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 August 2018 and was unannounced.

Magnolia Court is a residential care home registered to accommodate up to 54 elderly people some of whom are living with dementia. The home is set over three floors with people's bedrooms on the second and third floor. The ground floor accommodates dining and living areas for people, offices, the kitchen, laundry and the hairdressers salon.

The service was last inspected in August 2016 and was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to insufficient staffing levels. We carried out a focussed inspection in July 2017 to check whether the service had made the required improvements. We found that the service had made the necessary improvements and was no longer in breach of the Regulation. We rated the service 'Good' overall. At this inspection we found the evidence continued to support the rating of 'Good' and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Risk assessments in place continued to assess risks associated with people's health, social and care needs. Risk assessments detailed how risks were to be minimised or eliminated in order to keep people safe and free from harm.

Robust medicine administration and management processes were in place and followed to ensure people received their medicines as prescribed.

People and their relatives confirmed that they and their relative felt safe living at Magnolia Court. Care staff described the steps they would take to report any concerns relating to suspected abuse.

We observed there to be sufficient numbers of care staff to meet the needs of people living at the home.

Safe recruitment processes ensured that only staff assessed as safe to work with vulnerable adults were employed.

We observed positive and caring interactions between people and care staff. Care staff knew the people they supported well and had built relationships with them and their relatives based on trust and mutual respect.

Records confirmed that care staff were supported through training, supervisions, annual appraisals and team meetings.

People's needs and requirements were comprehensively assessed prior to admission to Magnolia Court to determine that the home would be able to effectively meet the holistic needs of the person.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Care plans were detailed and person centred and clearly reflected people's needs, choices and preferences. These were reviewed regularly.

People were seen to enjoy the meals provided. People were offered choice and always had access to a variety of drinks and snacks throughout the day. Where people had specialist dietary requirements these were appropriately met.

People had access to a variety of health care professionals where specific needs or concerns were identified.

People and relatives knew who to speak with if they had a complaint and were confident that the issues that they raised would be appropriately addressed.

The registered manager and provider had robust governance processes in place which allowed them to monitor, evaluate and improve the quality of care provision. Where issues were identified systems in place allowed for the service to address these and to continuously learn and improve.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Magnolia Court

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 was a comprehensive inspection and took place on 30 and 31 August 2018. This inspection was unannounced.

This inspection was carried out by one inspector, one specialist advisor nurse and two experts by experience who spoke to people at the home and made telephone calls and spoke with relatives of people using the service. An expert-by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete 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 reviewed the completed PIR and previous inspection reports before the inspection.

We also reviewed information we had about the provider, including notifications of any safeguarding or other incidents affecting the safety and well-being of people using the service.

We spoke with seven people who used the service and 16 relatives. We also observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

We spoke with the registered manager, senior regional manager, deputy manager, two nurses, four care staff, the chef, the maintenance manager and the laundry assistant. We also looked at eight staff files and training records.

We looked at 13 people's care plans and other documents relating to their care including risk assessments

and medicines records. We looked at other records held at the home including staff meeting minutes as well as health and safety documents and quality audits.

Good

Is the service safe?

Our findings

People and relatives expressed confidence receiving care and support from care staff at Magnolia Court. One person told us, "I had a few falls in the hospital before I came here. Here they changed me to this room because it's near the nursing station, just in case I fall." Relatives told us, "I am happy that my [relative] is there. I feel she is safe", "They [care staff] look after her [relative]. There is always someone around her" and "I was so worried at the last care home. Here I feel my [relative] is safe."

Care staff demonstrated a good level of understanding about safeguarding and recognising potential signs of abuse. They were able to explain the steps they would take to report abuse to protect people if abuse was suspected. One care staff told us, "It is very important that you report and record it, tell the senior who reports to the manager who will report to the local authority safeguarding team." Care staff understood the meaning of whistleblowing and listed names of agencies including the CQC and the local authority who they could contact to express their concerns without fear of recrimination.

Risk assessments were comprehensive and detailed, identifying people's risks associated with their health and social care needs. Risks identified included, use of bed rails, choking, pressure sores, moving and handling, skin integrity and specific health conditions such as epilepsy and diabetes. Risk assessments detailed the risk, the severity of the risk and the actions to be taken to reduce or mitigate the risk to keep people safe and free from harm. All risk assessments were reviewed monthly or sooner where needs had changed.

Medicines management procedures remained robust. People received their medicines safely and as prescribed. Medicines were stored securely and medicines stocks were well managed. 'As required' (PRN) medicines and 'homely remedies' (medicines which can be purchased over the counter) were administered safely following clear directions on when and how they should be administered. PRN medicines are administered on an 'as and when required' basis and include medicines such as pain relief.

A number of people received medicines which were disguised in food or crushed. Where this was the case there was clear guidance on the administration of covert medicines with the recorded involvement of the home, the GP, the pharmacist and the family. Controlled drugs were stored appropriately and were signed by two staff when administered. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

We looked at medicine administration records for people living at the home and found these to be clear and fully completed. The records showed people were getting their medicines as prescribed and any reasons for not giving people their medicines were recorded. Staff responsible for the administration and management of medicines had received regular training in safe medicine management which included the completion of a competency assessment. Senior managers completed daily, weekly and monthly medicine audits which identified and addressed any gaps in recording or errors to ensure the safe administration of medicines.

The service completed a level of need assessment for each person living at Magnolia Court which allowed

the service to determine staffing levels required at the home to safely support people with their needs. Throughout the inspection we saw sufficient numbers of care staff available and they were not rushed. People and relatives confirmed that care staff were always visible and available to support them and their relative.

Recruitment processes in place were robust to ensure that staff only assessed as safe to work with vulnerable adults were recruited. Checks included obtaining references of conduct in previous employment, disclosure and barring criminal record checks and identity checks.

Accidents and incidents were clearly documented with details of the incident and the immediate actions taken. Following a review by the deputy manager and/or registered manager all follow actions were also recorded. All accident and incident information was then sent to the senior regional manager and the provider for oversight. Each accident and incident were also discussed at daily clinical meetings and monthly clinical governance meetings so that any trends or patterns could be identified and to discuss any learning or improvements that could be made as a result to prevent any such future re-occurrences.

We observed that the home was clean and free from malodours. All staff received infection control training and had access to a variety of Personal Protective Equipment (PPE) such as disposable gloves and aprons. We saw that all food preparation and storage areas were clean and appropriate food hygiene procedures had been followed.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety, legionella and hoisting equipment were undertaken.

Individualised Personal Emergency Evacuation Plans (PEEPs) were in place for each person and the provider had a clear plan in place to help ensure people were kept safe in the event of a fire or other emergency.

Good

Is the service effective?

Our findings

During the inspection we observed care staff to be competent and knowledgeable when delivering care and support. This was also confirmed by people and relatives that we spoke with. One person explained, "The staff are unflinching in their dedication. They always think of what they should be doing, they're not wasting time. The attention here is excellent. They always visit all day long. A severely ill person, they check every half hour. The doors are always open." Relatives told us, "The staff are knowledgeable" and "The training here is absolutely remarkable."

Care staff told us and records confirmed they had regular opportunities for training and skill development and we saw during our visit training sessions being delivered. Topics of training delivered included, safeguarding, Mental Capacity Act 2005 (MCA) and first aid. All newly appointed staff underwent a 12 week induction period which included shadowing more experienced care staff whilst undertaking care tasks to enable them to get to know people as well as build on their confidence. One staff member told us, "I have mentored new staff to the home be it nursing or care staff." Care staff also confirmed that they were supported in their roles through regular supervisions and annual appraisals and were given the opportunity to raise concerns and discuss their development.

People's needs were assessed prior to their admission to the service. Care and support was then planned in response to their needs. Assessments included information on the person's general health, medicines, hearing and vision, dietary needs, communication, sleep, continence, mental health and their likes and dislikes. Monthly assessments and reviews were completed to check whether the person's needs were changing and care plans were amended accordingly where change had been noted to ensure that care provision was current and reflective of the person's needs and wishes.

People were supported to eat and drink in a personalised way which enabled them to be as self-supporting as possible enabling them to maintain their dignity and privacy. During the inspection we observed the dining experience for people. We saw care staff serving the meals in a considerate and timely fashion. People were offered visual choices of which meal they wished to have. We saw people had access to drinks and snacks throughout the day. People's care plans reflected their likes, dislikes and cultural requirements in relation to their meals and drinks. Where people had been assessed as requiring specialist or one to one support with their meals this had been documented within the person's care plan and we observed appropriate support was provided.

The registered manager gave a number of examples of how they worked as a team and in partnership with other organisations and health care professionals to ensure people received the appropriate care and support that they required. Daily handovers, clinical lead meetings and progress and evaluation records allowed for immediate and significant information exchange. We also saw correspondence and referrals between the service and a number of health care professionals specifically around people's health needs. For example where concerns were noted of potential weight loss referrals had been made to a dietician and appropriate steps had been taken to ensure the person received appropriate supplements and that the person's weight was monitored frequently.

Care records showed people had access to and input from a variety of health and social care professionals and specialist services including the GP, chiropodists, opticians, audiologists, the mental health team, occupational therapists and palliative care nurses. Records included details of the visit and any subsequent actions following the visit. We spoke with one visiting chiropodist who told us, "I have visited three other home but this was the best and it is great when I come here."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the service was meeting the requirements of the MCA 2005 and the Deprivation of Liberty Safeguards.

Where people lacked capacity, assessments had been completed and best interest meetings conducted to further determine the level of support that the person would require that would be in their best interest. This included decisions around administration of covert medicines, moving to a care home and do not resuscitate authorisations. Records confirmed the involvement of the home, relatives and any associated health care professionals in best interest decisions.

People, where appropriate, had signed their care plan consenting to the care and support that they received. Where people were not able to consent, relatives had been consulted and involved in the care planning process and this had been documented in the care plan. Senior managers as well as staff members demonstrated a good level of understanding in relation to the MCA and its principles and how this may affect a person that they supported.

The home was adapted in a way which supported people's individual needs. A lift enabled people to access all areas of the home. Where specific moving and handling equipment was required including hoists, wheelchairs and adapted shower chairs and baths, these were available. People's rooms were personalised as they so wished. Use of dementia friendly signage and pictorial aids were visible around the home.

Good

Is the service caring?

Our findings

People and relatives used words such as, "caring", "lovely", "excellent" and "wonderful" to describe the care staff who supported them. Relatives' feedback was very positive and included, "The staff are so caring. They look after her. There is always someone around her", "They are lovely. So kind with my [relative]" and "They are very kind and thoughtful and the carers all have a smiley attitude."

Throughout the inspection we observed positive and caring interactions between people and the care staff that supported them. Care staff approached and talked with people in a warm and gentle manner. Care staff knew people well and also engaged very well with visiting relatives. One care staff told us, "We get to know the resident and their families which takes time and patience." We saw care staff involving people in making day to day decisions about the care and support they received. During lunch time we observed one care staff ask a person, "Shall we go to have some lunch." The person replied, "Yes please!"

Care plans detailed people's preferences and wishes on how they wished to be supported. Records of regular review meetings also evidenced the involvement of relatives and advocates where appropriate which relatives whom we spoke with confirmed. One relative told us, "I have seen the care plan, they ask me to look at it periodically and they talk to me every day." Another relative stated, "They [service] did try and get us involved and I do feel involved in the process but [relative] knows what he wants and they [care staff] and do it."

We saw that care staff were attentive to ensure that people's privacy and dignity was maintained at all times. We noted that care staff knocked on people's bedroom doors before entering and ensured privacy was maintained when supporting the person with personal care. People and relatives confirmed that care staff always treated people with respect and ensured their privacy and dignity was always maintained. One person stated, "The staff ask for consent and give you privacy." One relative stated, "My [relative] is treated with dignity and care."

Care staff had a good understanding about person-centred care. One member of staff said person-centred care was when you, "Think about how you would like to be treated, and think about the needs, wants, choices." Another member of staff explained that people, "Have different care needs and you give care the way our residents want it." People were supported to maintain their independence as far as practicably possible and had access to all areas of the home including the garden and patio areas.

Care plans were reflective of people's cultural, religious and personal diversity and staff were clearly aware of people's individual needs and how these were to be met. People living at the home were predominately Jewish and so religious festivals were observed in accordance with the Jewish faith. Where people belonged to different religious faiths people were supported to observe their faith. This included a visiting priest who delivered weekly holy communion for those people who followed the Catholic faith.

Good

Is the service responsive?

Our findings

Care plans were comprehensive and gave detailed insight into people's needs, choices and wishes on how they wanted to receive care and support. Identified areas included communication, personal hygiene, mobility, nutrition and hydration, sleeping and mental health and cognition. Each section recorded the person's personal outcome in that particular area and the plan of care which care staff were required to follow. Following each section any associated risk assessments had been completed giving staff guidance and direction on how to support the person responsively and safely.

We saw that the service was also responsive where specific needs or concerns about people's health and care had been identified. For example, we saw in people's bedrooms, monitoring charts for food and fluid intake, re-positioning charts and well-being, which enabled care staff to monitor people's identified concerns and provide responsive care and support as required. Records were complete and allowed care staff to continually monitor the person and where required increase or decrease the level of monitoring, care and support based on how the person was responding.

People's likes and dislikes had been clearly documented along with indicators for care staff to identify where an individual was not in a positive state of well-being. This enabled care staff to respond to people's emotional and physical wellbeing in a way which was personal and responsive to their needs. One care staff told us, "We get to know the resident and their families which takes time and patience. I want to learn how to deal with difficult situations so I don't make things worse."

Each person had a life history document which charted the person's life, involved people in their life and significant life events. The document also detailed people's known interests and hobbies as well as a section that was called 'All about me' which listed people's likes and dislikes and personality traits. The information enabled care staff to gain a better understanding and appreciation for the people that they were caring for.

Activity boards detailing activities scheduled for the day and month were on display at various sites around the home. Activities included board games, music therapy, quizzes, songs of praise, reminiscence therapy and outings. We observed people participating in organised activities throughout the inspection and where activity was promoted people were enabled and encouraged to achieve what they could. People's care plans also listed their interests and hobbies so that care staff could plan and organise activities based on what people enjoyed doing in the past. Where people were in their own rooms, potential activities that they could engage in on a one to one basis, for example therapeutic hand massage, had been documented.

Care staff were also able to demonstrate their understanding of person centred care and how this translated into the care and support that they provided to each individual. On the day of inspection one person was being escorted home by a care staff. The purpose of the visit was to check for mail and to see if everything was okay with his house. The person did this on a weekly basis and by so doing maintained a sense of independence.

The provider had developed a dementia programme to enhance the dementia care environment and

improve interactions between people living with dementia, care staff, relatives and health professionals. Magnolia Court had introduced this methodology within the care home which had involved significant changes to the environment and upskilling care staff to deliver on its core values which were to proactively work in partnership to reduce stress, increase wellbeing and improve people's quality of life especially for those living with dementia.

End of life preferences and wishes were noted within people's care plans. Details included the person's wishes, religious and cultural preferences on what they wanted to happen following their death and pre-agreed funeral arrangements. We saw evidence that these discussions had taken place involving the person, their family and a multidisciplinary team where appropriate.

A complaints policy was available and displayed around the home which detailed the processes in place for receiving, handling and responding to comments and complaints. People and relatives we spoke with told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. Relatives comments included, "No complaints so far. I feel there is nothing to be improved" and "I am pretty satisfied so nothing to complain about."

Good

Is the service well-led?

Our findings

A registered manager was in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives told us that they knew the manager and the management team and that they were always visible around the home. One person told us, "The management is very good, the new lady, [name of registered manager]. If I need something I go downstairs to the reception." Another person stated, "[Name of registered manager] comes round regularly and asks people how they are getting on."

Care staff told us that they 'loved' working at Magnolia Court and that the manager and management team were very supportive of them. Comments from care staff included, "I love the home and the staff I work with are great. The manager is very approachable and is always available" and "I have been here for two and a half years. I love the home, the manager is fantastic, she can solve problems. I miss it when I have a day off and quite often I will pop in as I live nearby."

Records confirmed and care staff corroborated that they were well supported in their role, through a variety of processes which included supervisions, appraisals, handovers and staff meetings. Care staff told us that they felt enabled to put forward their ideas and suggestions on how people should be supported and the areas for improvement.

During the inspection we were given information about reward schemes that the provider offered to all staff as part of their employment contract. This included access to employee discounts, profit share scheme, employee of the month award and long service awards. This ensured that staff morale was always maintained at a high level and that they felt valued and recognised for the work that they do. In addition the completion of annual staff surveys enabled the provider to obtain insight into how staff felt about working for the service and where required initiate required improvements in areas that care staff identified through the survey.

People and relatives were encouraged and supported to engage in giving feedback, their views and suggestions through regular resident and relatives meetings as well as completing annual surveys. The annual survey results for 2017/2018 were positive and a report was compiled with the analysis of the results. The service promoted an open and transparent ethos and ensured that the results of every completed survey was displayed in the main entrance of the home so that all people, relatives and visitors were able to view the comments made and the actions that the service had taken under the heading 'You said, we did.'

The registered manager and provider carried out a number of checks and audits to monitor and oversee the quality of care and support that people received. This enabled the service to learn and improve the quality of care where required. Checks and audits included oversight of medicines management, care plan audits, health and safety checks, nutrition and hydration management and observing the dining experience for

people. Where issues were identified, an action plan was formulated so that details of the issue and the actions taken could be monitored by the registered manager and the provider within a specific timeframe.

People and relatives confirmed that the communication between them and the service was very good and that they were always kept updated about areas concerning their or their relative's health, care and well-being. One person told us, "The management and staff make the adjustments. They are getting me a new mattress." Relatives' comments included, "Communication is very good. They keep me updated with everything" and "They always have to time to see me and update me of what is going on."

The service worked in partnership with a variety of healthcare professionals and community organisations. We noted that that the service maintained positive links with healthcare professionals including the GP, physiotherapists, speech and language therapists and a local hospice. The service encouraged visits from the local community which included local schools and religious institutes. This combined partnership approach ensured that people living at the home had access to a range of holistic services which supported their health and well-being. The service also engaged the local authority and local care homes to share practices and common issues that affected the management of a care home.