Magdalen House Limited

Magdalen House Care Home

Inspection report

Magdalen Road
Hadliegh
Ipswich
Suffolk
IP7 5AD

Tel: 01473829411

Date of inspection visit:
09 June 2016

Date of publication:
08 August 2016

Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was unannounced and was a responsive inspection. The purpose of this inspection was to follow up on a number of concerns which related to people's safety and well-being. We passed these concerns on to the Local Authority safeguarding team so they could be investigated. The Local Authority found most concerns to be unsubstantiated. The provider is usually proactive in raising concerns with the safeguarding team but a number of issues had not been reported by previously employed staff.

We also inspected the service to determine if people were receiving safe care and to assess if the service was being well managed with an adequate number of staff.

The last inspection to this service was on the 25 May 2015 and the service was rated good in all the outcomes except safe which required improvement. At our inspection on the 09 June 2016 we also regarded safe as requiring improvement but there was no change to the overall rating.

This report only covers our findings in relation to Safe. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Magdalen House on our website at www.cqc.org.uk.

The service provides accommodation and care for up to 53 people and it was situated on three separate floors, One is a designated dementia care unit, the other a residential unit and the third unit was for people who are more independent.

There was no registered manager in post. 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.

Since the last inspection in May 2015 the Registered manager and Deputy Manager had left. This led to a degree of uncertainty for the staff and people using the service. An acting deputy manager had recently been appointed and we found that they were experienced and knew people's needs well. They were supporting staff who told us they had confidence in their skills. The provider was providing leadership and had acted quickly to address the management shortfalls. They told us they had already appointed a new manager and would support them through their induction.

Staff had knowledge about safeguarding people in their care however there had been a failure to report matters of concern. These concerns were being investigated by the Local Authority. The provider acknowledged this was an oversight but one which would be rectified.

There were not always enough staff to match the dependency levels of people using the service. Staff told us changes in management had affected staff morale, but said that they enjoyed working at the home and seemed to be happy with the present acting up/interim management arrangements. However staff

shortages meant that some staff were not familiar with people's needs and were not sufficiently experienced. There had not always been enough to staff to provide adequate stimulation or activity to promote people's well-being. The provider had a plan to address this.

We have made a recommendation about audits to include call bell response times as this is a good indicator as to whether there are enough staff.

Risks to people's safety appeared well managed and health care professionals reported favourably about the care provided in the home.

People received their medicines as required by staff trained and assessed as competent to administer it.

We found a breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff to match the dependency levels of people using the service.

Staff had a good understanding of how to raise concerns and protect people as far as possible in their care. However a number of safeguarding concerns had not been reported as required, the outcome of these is not known.

Medicines were administered according to people's needs and as prescribed by the GP.

Risks to people's safety were well managed but concerns were expressed about some staffs competencies and skills.

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.

The inspection took place on the 9 June 2016. The inspection was unannounced. The inspection was carried out by one inspector and one 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.' Our expert had experience of older people care in various settings.

Before our inspection we received some information of concern from a number of different sources. We used this information to plan our inspection and passed the concerns on to the Local Authority. Before the inspection we looked at previous inspection reports, and notifications which are important events the service are required to tell us about.

During our inspection we carried out observations on each of the floors. We spoke with the provider, acting manager and, two senior care staff, three care staff and carer/activities coordinator, the catering manager and domestic assistant. We spoke with 12 people using the staff and three health care professionals. We looked at two care plans and a number of other records relating to the running and management of the business.

Requires Improvement

Is the service safe?

Our findings

The purpose of this inspection was to follow up a number of concerns which had been received about the service which would suggest the home was not always safe and there were not always sufficient staff on duty. On the day of our inspection there were enough staff to meet the needs of people using the service. However we were told that staffing levels fluctuated and this impacted on how care was being provided and meant people did not always receive timely care.

We were told there were usually five carers on the first floor/there were four on the day of inspection and they were supported by a senior carer. We observed staff working in a cohesive way and saw that staff were attentive to people's needs but very busy throughout the day. Staff described the home as hectic at times and staff said they could be asked to work with less staff particularly at the weekends. It was difficult to see how the home would operate effectively with less staff due to the demand on their time. We also saw staff were deployed from one floor to another which effectively reduced support to the home as a whole. We looked at staffing rotas which were issued to staff for the month ahead which showed shifts were not always fully covered. However we did not view the daily allocations sheets which we were advised after the inspection would show how these gaps had been covered and actual numbers of staff working.

From feedback received before and at the time of our inspection we were not confident that there were always sufficient staff on duty for the needs of people using the service or that all staff were sufficiently competent and skilled. One person told us that some staff on nights did not speak much English and that this could be difficult. Staff said some training had been cancelled recently so was not all up to date. People using the service told us staff were friendly, kind, caring and respectful of their privacy and dignity, but that the home seemed to be understaffed at times. One person said, "Staff work hard, but they're a bit under staffed"; another said that he thought the home "Could do with more carers and seems to have no backup plan to get extra staff when they need it."

Staff also told us more care staff were needed to address the needs of people who were identified as having high needs (particularly dementia) and on night shifts. Staff said they needed more time to provide activities. Staff also felt at certain times a day time was very pressurised and a times they were not able to assist people up at the time of their choosing. Concerns received before the inspection suggested sometimes people were not up much before lunch time but this was not evident on the day of our inspection. We did observe activities taking place on the day of our inspection but the two designated activity staff had both recently been on extended leave which had affected the availability and range of activities provided to people putting more pressure on care staff.

Fluctuating dependency levels of people using the service at times appeared to put additional pressures on staff time. Staff reported one person who came in for a period of respite care could take up to three staff to support them. The acting manager said this was not the case but staff felt it was and this meant there might only be one member of staff left on the floor. There were usually four staff plus a senior on each floor but we saw the seniors were really busy throughout the shift and involved in separate tasks such as medication administration and dealing with health care professionals. Care staff said senior staff did not always have

time to support them with direct care. The home did have a recognised tool to help them determine people's needs and from there work out how many staff they needed. However this was being done on a three monthly basis which did not take into account peoples changing needs. We acknowledged that there had been a number of changes in staffing of late and a recent outbreak of infection had affected some staff.

We identified a breach in Regulation 18, Staffing

People told us call bells were normally answered in 5 to 10 minutes, but there were often longer delays when call bells were rung at the same time. Throughout our observations we saw call bells took up to ten minutes to answer and were going off frequently. We observed people getting distressed particularly one person who was newly admitted to the home and disorientated with their surroundings.. The provider said they could not print off how quickly an alarm was answered as the system did not have the capacity to do this. We saw from recent audits there was no mention of response times to call bells so we were unable to see how the home monitored this.

We recommend that the service records call bell response times at busy times of the days which were reported to be early morning and late evening. This would help identify if there were sufficient staff to meet people's needs in a timely way.

We spoke with people using the service. They told us they felt safe in the home and safe when being helped by their carers. One person told us, "I feel safe when they're helping me have a shower." Another said "I feel safe when they're lifting me up from the chair." However one person told us "some of the staff can be a bit rough in the way that they help you, but if you tell them they change." We had concerns raised with us about some of the staff's manual handling practices and although we observed good practices on the day, some staff said the training they had received was not very comprehensive. One staff said their training was half an hour. Competency assessments on moving and handing to demonstrate staffs competence were not in place.

Access to the home is by security pad activated by staff. The Catering Manager said that a new security pad had been installed to stop people being able to enter the kitchen. We received information from a whistle blower about door entry codes being readily available. The provider said they would consider changing this as they had number of staff recently leave but said they did not want to restrict visitors coming freely to the service to visit family members.

We spoke with a number of health care professionals who all said the staff knew people's needs really well. They said they made referrals as required and had the information to hand over about people. No concerns were raised about people's care or risks to their safety although it was felt recent changes to the staffing team and some staff changes had destabilised the service a little but things were improving. One person had recently fallen and staff as a precaution had sent them to hospital and had followed this up with a visit from the district nurse on discharge to ensure their health care needs were met.

We noted people had appropriate equipment to help keep them safe. Bedrails were not used so people had pressure relieving mats to alert staff when people were mobilising. Care plans contained good detail as to people's needs and how staff should meet them. There were detailed risk assessments including as to whether people could use their call bell and how often they should be checked for their safety. There were assessments for skin care, risk of falls, nutrition and hydration. We could see actions were carried forward and people's health care conditions were monitored. We noted where people had behaviours which disturbed others this was being managed by the home and referrals to the mental health team had been made. However people's records did not always record positive behavioural strategies or how staff could try

and support the person to minimise their anxiety. Staff reported difficulty in meeting the needs of people with dementia.

We recommend the home provides dementia care training for all its staff and ensure they have sufficient knowledge of the needs of people with dementia.

We spoke with people about their medicines and people were able to tell us that they received medicines as required. We observed medicines being administered on both floors by staff that had been trained to administer medicines. They told us it could take up to two hours on each floor. However they said this was because people were not always cooperative so they would try additional times to see if they would take it which they usually did. They also said some medicines were time critical so this also took time to administer at differential prescribing times. We observed senior staff taking the time needed to assist people taking their medicines. The senior carer on the ground floor was observed issuing drugs from the drug trolley wearing a do not disturb vest and updating records throughout the round. We observed one person whose medicines had been left with them to take and were told staff would observe them from a distance. No staff were present at the time and this is unsafe practice as staff signing for their medicines could not be assured they had taken their medicines.

We found medicines were well organised in a designated room and medicines were secure and stored at the correct temperature. For each person there was a photograph and a list of medicines they were taking and any specific instructions. There was one person who was responsible for taking their own medicines and they had signed a consent form. This was kept under review. Care plans included details of people's medicines and how they liked to take it. No one had their medicines covertly.

We saw the last medication audit was completed in April 2016 and the acting manager also said external audits were carried out but these could not be found. They had recently taken over responsibility for ordering medication and were not clear about the auditing processes. We raised this with the provider who said this would be handed over from themselves to the new manager. Following the inspection they carried out a self-audit and found they scored over 90 %. They also arranged for the supplying pharmacist to repeat an audit and this is now booked in. We saw some daily audits, particularly for controlled drugs and checks on medication records and stock checks. We had asked cream administration to be included as part of the overall audit to ensure staff were signing correctly for creams.

Not all staff were aware of the pain assessment tool which should be used to assess a persons pain level when they might not be able to verbalise this.

We received information of concern about missed medication/signatures but found no evidence of this. However not all staff were aware of the procedure should medication be missed. The home have a specific medication error form which the provider said should be used and will ensure all senior staff are made aware.

Staff received training to enable them to administer medicines safely. Staff were initially shadowed until they were confident to administer medicines themselves and competency assessments were completed.

We observed the home to be clean with no odours. There were domestic staff on each floor and we saw regular and deep cleaning schedules taking place. Concerns had been raised before the inspection about a recent infection outbreak and how this had been managed. However the home had managed this appropriately and managed to contain the outbreak. They had given information to staff about infection control procedures and staff had the necessary equipment. Since the outbreak Public Health England-

infection control nurse has offered support to the home around infection control and the home have taken up their offer.

Staff knew how and when to raise concerns if they suspected a person to be at risk of abuse. They had received training and had access to policies and procedures. However the service had failed to report a number of concerns as required to the Local Authority. This has since been rectified and was an oversight of the staff employed at the time The provider told us that they had taken steps to address this and was in the process of carrying out investigation.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet the assessed needs of people using the service.