Care Management Group Limited

# Care Management Group - Magnolia Cottage

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Requires Improvement |
| 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 9 November 2016 and was announced.

Magnolia Cottage provides a home and support for a maximum of four people with a learning disability. The home is a bungalow in keeping with others in the local community. At the time of our inspection, there were four people using the service.

There was a 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.

Staff promoted people's safety. They understood their obligations to report any concerns or suspicions that people were at risk of harm or abuse. There were enough staff to meet people's needs and they were recruited in a way that contributed to protecting people from the employment of staff who were unsuitable to work in care.

Risks to people's safety and welfare were assessed with guidance for staff about managing these. Staff knew how to respond if there was a fire or an accident in the home so that people's safety was promoted. The registered manager kept the safety of the service under review. This included ensuring that staff managed medicines safely.

The level of staff turnover raised potential problems for people living in the service. The management team and relatives recognised that people needed support from consistent staff. There were some staff who had developed a good insight into people's specific individuals needs and how they communicated. However, there were many new staff who needed to develop their skills and knowledge to support people with complex needs.

The registered manager and regional director identified the need for additional support, coaching and training for staff. They had recognised the need to improve written guidance about people's care in order to support staff, particularly new staff members, to understand and meet individual needs. They had put plans in place to achieve this.

Staff were aware that any action they took to ensure people's safety and welfare should not restrict them unreasonably. Longer standing staff members understood how people communicated their consent to receiving care. They involved family members who knew people well to help participate in planning how people's needs could be met. However, staff were not consistently clear how people's capacity to make specific, individual decisions about their treatment should be looked at.

People received support to eat and drink enough to keep them well and healthy. Staff ensured they sought

guidance from professionals and acted on advice from them to promote people's physical and mental wellbeing. They understood the signs that people might show if they were becoming unwell or in pain so that they could respond promptly.

Staff treated people warmly and with regard to their dignity, privacy and independence. They took action to intervene if people were upset, anxious or distressed and understood how people might express this.

There had been a period of inconsistent leadership within the service, which had affected the morale and motivation of staff. This contributed to a lack of clarity about staff roles and accountability. The new registered manager had been in post for only five weeks at the point of this inspection, but was already making improvements to the quality of care people received, how staff were supported and listened to, and how the views of relatives were considered. They had identified with the regional director, priorities for further improvement and established clear systems for checking and monitoring 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.

People were protected from the risk of harm and abuse and staff knew they needed to report any concerns.

There were enough staff to support people safely and recruitment processes contributed to protecting people from abuse.

Medicines were managed safely.

Risks to people's safety and welfare were assessed and staff understood how to minimise these.

### Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff were skilled in meeting people's specific needs and further training and coaching was needed.

Staff understood their obligations to consider people's best interests. However, they were not always clear how people's capacity to give consent needed to be specific to each individual decision.

People were supported to have enough to eat and drink to ensure their health.

Staff supported people to seek advice from professionals to support people with their physical and mental wellbeing.

### Is the service caring?

Good

The service was caring.

Staff treated people with warmth and respect for their dignity, privacy and independence.

Staff understood how people communicated and involved relatives in helping to support people express their views about

their care.

## Is the service responsive?

Good

The service was responsive.

Experienced staff understood people's individual needs and preferences and how to meet them. Improvements were planned so that care records would be more specific about individual needs.

People's representatives had confidence that the manager would address their concerns or complaints.

## Is the service well-led?

Good

The service was well-led.

The new registered manager was providing good leadership and direction for the staff team.

The registered manager was open to the views of people using the service, their representatives and staff and took these into account.

There was a system for checking and monitoring the quality and safety of the service and identifying improvements that could be made.

# Care Management Group - Magnolia Cottage

**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 9 November 2016 and was announced. The provider was given 48 hours' notice because the location was a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in. It was completed by one inspector.

Before the inspection, 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. The previous registered manager completed this and returned it when they needed to. We reviewed the content of this. We also looked at all the information we held about the service. This included information about events happening within the service and which the provider or manager must tell us about by law. We sought feedback from the local authority's quality assurance team.

During our inspection, we observed interactions between people living in the home and staff. We interviewed two members of staff and the registered manager. We reviewed records relating to the care of three people and medicines records for two people. We reviewed recruitment records for one member of staff, training records for the staff team and a sample of records relating to the quality and safety of the service.

After our inspection, because people living in the home found it difficult to communicate their views verbally and in detail, we contacted relatives for two people to gather their views. We also asked for some additional information from the regional director about monitoring and auditing processes. They supplied this promptly.

Good

# Is the service safe?

## Our findings

People's relatives told us that they felt their family members were safe at the service. One relative said, "I don't have any worries about [person's] safety." Another told us that staff, "…deal with things in a way that ensures [person's] safety." They went on to comment that they trusted the staff.

Staff were clear about their obligations to report any concerns that someone might be at risk of harm or abuse. Staff had Information on the noticeboard in the kitchen for to refer to should they need further guidance and contact numbers to report concerns. The staff message book contained details of a telephone number staff could contact if they needed to report any concerns about poor practice.

A staff member explained how they responded to behaviour that might place a person or others at risk. They told us that they did not restrain people and described how they would divert people elsewhere in the home to minimise risks, if it was necessary. Staff had access to information about risks to people, with information about how to minimise these so that people's safety would be promoted. This included risks from falls, epilepsy, and going out in the community. The registered manager had checked these to ensure they remained appropriate.

There were arrangements in place to help promote people's safety in the event of an emergency. There were regular tests on fire detection equipment to ensure this would work properly to raise the alarm. Staff were aware how they should support people to evacuate the home in an emergency. They were also aware of the importance of explaining fire safety arrangements to visitors to the home, including the inspector. Staff had access to training in first aid so they could respond to an emergency affecting someone's health.

Medicines were managed safely. People's relatives told us that they felt staff dealt with their family member's medicines appropriately. Staff, who were responsible for administering medicines, said they had received relevant training to do this safely. We saw that staff stored medicines safely and keys were secured to prevent any unauthorised access to them. Each person had their own, locked cupboard for their medicines. Medicine administration record (MAR) charts we reviewed were completed appropriately.

Staff told us about the checks they made to help ensure they administered medicines safely and as expected. They confirmed that no one living in the home was given their medicines hidden in food or drink. Staff told us how they gave one person their medicines with yoghurt or jam to help them with swallowing. Staff explained that the person was able to see the medicines and refuse them if they wished.

Staff recorded the amounts of medicines received into the home and made regular recorded checks on the balances of these. This helped to ensure they were all accounted for. There were mistakes in records presenting concerns that there were fewer tablets remaining than there should have been. However, we were able to establish that the medicines were all accounted for and given as intended by the prescriber. The registered manager undertook to review what had happened with the records so that the daily audit was clearer and accurately recorded.

There was clear guidance for staff about medicines prescribed for occasional use (PRN medicines), including when people became anxious or distressed. The guidance explained what the medicine was for, when staff should consider its use and the process for authorising administration. There was information about the maximum dosage within 24 hours and the intervals between doses to minimise any risk of overdose. Records showed that staff did not use these PRN medicines regularly and tried other methods to assist people with their welfare before considering using medicines. This contributed to protecting people from over-sedation.

The registered manager told us about the expected and safe staffing levels within the service. We noted from the staff duty roster, that these levels were maintained. A staff member told us that staff were generally good at covering extra shifts when these were needed. They described staffing levels as, "…just about right." We saw that staff were available to support people promptly when this was needed.

Recruitment processes contributed to protecting people from staff who may not be suitable to work in care services. A new member of staff described their recruitment process, including how they had needed to provide a full employment history, references and proof of their identity. Recruitment records confirmed that enhanced checks were completed for new staff to ensure they were not barred from working in care. If checks revealed historical concerns, but did not necessarily make applicants unsuitable for care work, these were referred to one of the provider's representatives before applicants were confirmed in post.

Requires Improvement

# Is the service effective?

## Our findings

People's relatives expressed some concerns that there had been a high turnover of staff. One felt that this was unsettling for their family member who needed stable and familiar support. They were concerned that staff might not be able to meet the person's needs consistently and skilfully because so many were relatively new to the service. The provider's regional director acknowledged that the high levels of changes had led to anxieties for some people living in the home and their relatives.

We found that staff turnover within the service had affected the skills mix, experience and competence of those in post to meet people's needs consistently and effectively. The provider's information return (PIR) sent to us in May 2016, told us that seven staff from a staff complement of 12 had left in the year leading up to that date. The provider's regional director recognised that the staff team was relatively new and told us they needed, "…lots of training and coaching on the job and support."

The PIR showed that only one of 12 staff employed had completed the provider's training in "positive behaviour support." A staff member confirmed they thought this training was lacking for most of the staff now working in the home. This presented a risk that the staff team would not respond consistently, confidently and skilfully to behaviour that may challenge the service. The new registered manager had identified the importance of this training and had arranged for all staff to attend. They explained how it would be focused on the specific needs of people using the service.

Staff spoken with acknowledged that there was training they needed to complete or to update. One new staff member said they were receiving support from experienced colleagues during their "shadowing" shifts, so that they were learning about a person's needs. They were aware of the specific training that the registered manager had arranged and confirmed they would be attending. They told us they had not yet been told about other training they needed to complete and when but knew there was some e-learning available.

A staff member told us that they felt well supported by the new registered manager and now had access to supervision. The staff member told us they had not felt well supported in the past and had not received supervision for about six months. Supervision is needed so that staff have opportunities to discuss their work, performance and development needs. The staff member explained that the new registered manager and a previous temporary manager tried to ensure they had regular supervision and this was improving. We found that the registered manager had arranged a schedule to ensure that staff received regular opportunities for supervision and support.

The registered manager told us about plans to recruit a deputy manager and that the post was advertised at the time of our inspection. They felt that this would provide more regular support, guidance and coaching for staff and help contribute to stabilising the staff team. Both the registered manager and regional director recognised that stability was important in ensuring staff were able to meet people's needs effectively.

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 authorisation procedures for this in care homes 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.

Staff understood the importance of seeking consent from people and offering choices about their care. However, they were not entirely clear about the MCA and that people's capacity to make informed decisions needed to be based on the individual decision under consideration. For example, a staff member told us how one person was supposed, "…not to be able to make informed decisions." They disagreed with this and felt that the person was able to make some decisions.

We discussed this with staff and the registered manager. Decisions about people's capacity to give informed consent needed to be specific to the individual decision under consideration. We needed to be sure that staff understood that a 'blanket' assessment about a person's capacity to give consent to all decisions in their daily lives was not appropriate.

A staff member was able to tell us how they tried to offer information to people about care or treatment. They could use pictures or visits (for example to look at the dentist's surgery), to try to help people understand any treatment considered essential for their welfare. They were aware of the importance of involving others to ensure that decisions were taken in a way that represented the best interests of the person concerned.

The registered manager was aware of the requirements of the MCA and understood their obligations to promote people's rights and freedoms under the MCA and DoLS. Applications for authorisation under the DoLS had been made where it was appropriate. Pending the outcomes of these, they were aware of the importance of ensuring that people's safety was promoted by the least restrictive options to protect their rights.

People's care plans showed where staff needed to support each person in a way that might be restrictive, to ensure their safety. The majority of these had clear guidance about how staff needed to do this. However, we noted that one person's care records identified risks around access to food. This referred to the person being limited in their access to snacks but able to, "…earn …" extra snacks as a reward for assisting with more household tasks. This was unsigned so we could not see who was accountable for documenting the decision but someone had crossed it out. The registered manager agreed that this was an inappropriate method of managing the person's pre-occupation with food.

People had a choice of enough to eat and drink to meet their needs. The registered manager raised an issue about the way staff presented both sweet and savoury food on the same plate, so they could think about how they did this in future. One person nodded that they were enjoying their lunch. Staff monitored people's intake if this was needed to check whether people had enough to eat and drink. There was guidance available for them in the kitchen about healthy eating.

Staff monitored people's weights so that they could follow up any unexplained or unintended change with

dietary advice if necessary. They were able to tell us who was at risk of eating their food too quickly and choking, and how they managed this. They told us how people could make choices and be involved in menu planning within their home.

We saw that people were offered drinks frequently and encouraged to prepare these for themselves if they were able to do so. They also chose where they wanted to sit while they were drinking. One person needing assistance to drink was given this. We saw that a staff member sat next to the seat the person had chosen, and supported them at their own pace.

A relative told us they were happy that staff attended to any health needs their family may have. They said that they felt the staff team managed health problems pretty well. They said staff arranged appointments that the person was prepared to accept and kept them informed about the outcomes or any concerns about the person's welfare.

Relatives were aware that people had appointments with health professionals such as their doctor, dentist or optician when it was needed. They also had access to psychology and speech and language therapists if this was needed to promote people's physical and mental welfare.

Good

# Is the service caring?

## Our findings

Relatives told us that staff spoke with people politely and in a kind way. Although they expressed some anxiety about the level of staff changes, one told us, "Staff who know [person] well, have a good relationship with [person]." A staff member described how people were involved in selecting their 'key workers' who would provide them with closer support. This took into account the way that people responded to particular staff so that they could build up a rapport and positive relationship.

We saw that staff spoke with people calmly and respectfully throughout our inspection. We noted that, when people were engaged in activities such as making a drink, staff offered them praise in a way that was appropriate for their age.

Staff told us how they offered people choices in their daily care and routine. We heard staff asking people where they wanted to spend their time and what they wanted to do. An established staff member showed that they were aware of a person's history and knew how they demonstrated anxiety or distress. They were able to give us clear explanations about this and showed that they knew when to intervene quickly to offer support or reassurance.

Relatives also told us how they were involved in discussions about people's care. One described the service as, "…working in partnership…" with them and said, "We are very happy with where [person] is." Both relatives confirmed that they had regular updates about what their family member had been doing and were kept informed and aware of any issues. They told us how the service supported people to be in touch with them, arranging and taking people for visits if necessary. The service did not impose restrictions on when they could visit.

We observed that staff took care not to "take over" when people were doing things for themselves, such as making drinks. This contributed to promoting people's independence as far as practicable. They offered guidance or prompts when these were needed but encouraged people with their independence. We also noted that people were encouraged with other routine household tasks to promote or maintain skills, such as gathering their laundry or helping with shopping.

We noted that, when one person needed assistance with their personal care, staff guided and assisted them discreetly. Staff respected their privacy while their care was being delivered, ensuring the bathroom door was closed and secured.

We raised, with the registered manager, an isolated concern that information about one person was at risk of being shared inappropriately with a third party. We noted that the registered manager reminded staff about discussing people's personal information within earshot of others when incoming staff arrived for their shift. One person was sitting in an area where a staff member had not been able to see them as they arrived. We noted that this was likely an oversight and due to space constraints. We saw that staff then ensured they were mindful of how they shared information and the whereabouts of people who may overhear. This contributed to protecting people's confidential information.

Good

# Is the service responsive?

## Our findings

Relatives told us that they were invited to reviews of their family member's care. One commented that, although this was overdue, the registered manager was sorting it out. This contributed to involving family members in supporting people to be involved in planning their individual care. The registered manager was able to show us the action they had taken to try and secure involvement of service commissioners in completing the review as required. The information we saw showed that she had taken action quickly following her appointment when the person's relative had contacted the service.

The registered manager and regional director had identified that work was needed to ensure people's written care plans were sufficiently personalised and focused on each individual. We agreed with this view and found that less experienced staff may struggle to establish people's individual needs and preferences from their records.

There was variable practice in the way information showed each person's specific needs and preferences around their personal care. For example, one person's care records contained detail about their preferences and needs. It said that the person needed mild, hypo-allergenic products, gave some detail about what these were, and specified their preferred brand of toothpaste. For another person, their records showed that they liked to use bubble bath, toothpaste and deodorant. It did not specify their preferred brands or types, for example whether they liked a roll-on or spray deodorant and what fragrance.

However, the longer standing and experienced staff had detailed knowledge about each person. For example, where a new staff member was completing 'shadowing' shifts, we saw that an experienced staff member shared knowledge about how the person communicated and how they were to be supported. Another staff member had detailed knowledge about a person's likes and dislikes and how they communicated these.

We found that duty rosters showed staff were allocated to work with people on a one-to-one basis, to support them with their day time activities. During our inspection visit, two people went out separately with staff for the morning. They bought items they needed for themselves. One person was involved in shopping for an item needed for their home. Staff showed them and explained what they were doing while they assembled the item so that they were involved in the process.

Later in the day, we saw that staff engaged in discussion with the registered manager about possibilities for activities within the local community. The discussions had regard for people's individual interests and environmental factors such as noise or crowds, which some people might find difficult to cope with.

A relative expressed some concerns that a person's opportunities to spend time away from the home had decreased. They said that the monthly update they received indicated this. They were concerned that the updates showed the person spent a lot of time, "…relaxing at home..." where they had previously been more active at either a day service or further education. They felt that some difficulties the person experienced could be avoidable and due to being bored at times, but knew that staff changes could have made things

difficult. They were intending to discuss their views at a care plan review.

There was a system for dealing with and responding to complaints. Although people may find it difficult to raise concerns, efforts had been made to enable them to understand the process. There was a laminated booklet with photographs, showing how people could complain, who they could talk to and what they could expect. This was displayed on the noticeboard in the kitchen for people to refer to if they needed it.

In practice, people using the service would need the support of staff and relatives to express their concerns and to make a complaint. Both relatives expressed their confidence that they would be able to complain to the new registered manager if they needed to. They said that they had raised one concern with a key worker in the absence of a manager, but had not received a call back as they thought they should. However, they went on to tell us, "I would be confident I could bring up a complaint with her. I can raise anything with her."

Good

# Is the service well-led?

## Our findings

The service had a recent history of management changes, which compromised stable and consistent leadership. The previous registered manager had left the service in July 2016, after which there were temporary arrangements. A manager who was registered in respect of another, nearby service provided support but had additional demands upon their time. Our discussions with the new registered manager, staff and relatives, showed that there was an impact upon staff morale from leadership changes and staff turnover since early in 2016. We found that the appointment of a permanent manager had already led to an improvement in the leadership of the service and how people's views were taken into account.

The current registered manager took up their role about five weeks before our inspection visit and had considerable experience as a registered manager in another of the organisation's services. Our discussions with the registered manager showed that they were aware of their legal obligations for meeting standards. They were aware of the events that they needed to inform the Care Quality Commission about. They also understood the regulations they needed to meet in the way the service was operated.

A staff member told us that during the first half of 2016, staff meetings were not held regularly and were not well attended. We confirmed this from meeting minutes. The staff member did not feel clear about their role or that they were listened to. They told us this was improving and that there had been one staff meeting with the registered manager already since she had started work.

A staff member told us that they felt the registered manager was building up a good relationship with staff and people living in the home. We noted that staff on duty interacted freely with the registered manager, who asked questions of them about people's welfare and listened to their responses. The registered manager valued staff knowledge of the people they were supporting and we noted staff explaining people's interests and preferences to them.

Relatives told us that they had received letters about the management changes and who was now in charge of the service. Both had spoken to the registered manager, felt that she would listen to their views and was approachable if they needed to discuss anything.

The regional director confirmed that surveys asking people for their views about the service were due to be sent out by the end of November. This indicated that people or their representatives were consulted so their views could be taken into account in the way the service was developed and improved.

The registered manager had identified issues in accountability and consistency within the service, which had affected the way that quality and safety was monitored on a regular basis. They had taken action to allocate specific responsibilities for some daily checks to nominated staff members. They felt that this had improved the situation. A staff member expressed the view that staff were clearer in their roles now. They said they felt that checks, for example on medicines, water temperatures, cleanliness and food safety were no longer being overlooked.

We noted that, in some care records, the registered manager had reviewed assessments of risk to ensure these were accurate and up to date, showing how staff should manage and minimise risks. The regional director's audit identified other records as needing update and review so that new staff had clearer guidance and detail about specific, individual needs. The regional director was working with the incoming registered manager to ensure they were aware of previous issues within the service and the work identified as necessary to improve.

As a part of the process to drive improvements, the regional director completed regular audits of the service. The last completed report was in August 2016 and before the current registered manager assumed her post. We were advised that there would be a further audit in the near future to ensure issues were clearly identified with her and followed up.

The organisation providing the service had signed up to the "Driving Up Quality" code of practice for services supporting people with a learning disability. This represented a commitment to evaluating the quality of support people received against the code and nationally agreed standards of best practice. The regional director confirmed to us that an audit based on the code would be completed in the near future to assess where the service could improve further against the standards.