Park Lane Healthcare (Magnolia House) Limited

Magnolia House

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

The inspection of Magnolia House took place on 3 and 5 February 2016 and was unannounced. At the last inspection on 10/12/2013 the service met all of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations were superseded on 1 April 2015 by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Magnolia House provides accommodation and personal care for up to 96 older people. People who use the service may also have a physical disability, sensory impairment, mental health condition or be living with dementia. The home is situated in Cottingham, close to the city of Kingston Upon Hull, but in the East Riding of Yorkshire. The service is divided into four units: Maple Court, Willow Court, Cedar Court and Lavender Way. Maple Court is a separate unit where the safety of people living with dementia is more easily maintained, while the other three units are open plan and people can move between them at their will. Accommodation is mainly single occupancy with a selected number of bedrooms that are shared. A very high proportion of bedrooms have en-suite toilet facilities. There is a hairdressing salon on Lavender Way and a separate flat where one person lives that is much more independent and therefore has their own front door entrance with key. Gardens are extensive and secure.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager that had been registered and in post for the last four months. 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.

We found that people were protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding concerns. Risks were managed and reduced on an individual and group basis so that people avoided injury or harm, wherever possible.

The premises were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Staffing numbers were sufficient to meet people's need and we saw that rosters accurately cross referenced with the staff that were on duty. We saw that recruitment policies, procedures and practices were carefully followed to ensure staff were 'fit' to care for and support vulnerable people. We found that the management of medication was safely carried out.

People that used the service were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal regarding their personal performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing.

The premises were suitable for providing care to older people and we found that the unit designated to accommodating people living with dementia was also suitable for its purpose. Everyone that lived in Maple Court had their own front door in bold colours, with letter box, door knocker and memorable signage, so they could identify their bedrooms.

We found that people received compassionate care from kind staff and that staff knew about people's needs and preferences. People were supplied with the information they needed at the right time, were involved in all aspects of their care and were always asked for their consent before staff undertook support tasks.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible. This ensured people were respected, that they felt satisfied and were enabled to take control of their lives.

We saw that people were supported according to their person-centred care plans, which reflected their needs well and which were regularly reviewed. People had the opportunity to engage in some pastimes and activities if they wished to. These included activities to stimulate the brain, keep skills going or just for pure pleasure and occupation. People had very good family connections and support networks and family members were encouraged to be involved in people's care.

We found that there was an effective complaint procedure in place and people were able to have any complaints investigated without bias. People that used the service, relatives and their friends were encouraged to maintain healthy relationships together by frequent visits, joining in with organised events, telephone calls and letters.

We saw that the service was well-led and people had the benefit of this because the culture and the management style of the service were positive. There was an effective system in place for checking the quality of the service through the use of audits, satisfaction surveys, meetings and good communication.

People had opportunities to make their views known through direct discussion with the registered provider or the staff and through more formal complaint and quality monitoring formats. People were assured that recording systems used in the service protected their privacy and confidentiality as records were well maintained and were held securely in the premises.

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 because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Risks were also managed and reduced so that people avoided injury whenever possible.

The premises were safely maintained, staffing numbers were sufficient to meet people's need and recruitment practices were carefully followed. People's medication was safely managed and infection control practices were safe.

Is the service effective?

Good

The service was effective.

People were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal of their performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain good levels of health and wellbeing. The premises were suitable for providing care to older people and to those living with dementia.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff. People were supplied with the information they needed and were involved in all aspects of their care.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible.

Is the service responsive?

Good

The service was responsive.

People were supported according to their person-centred care plans, which were regularly reviewed. They had the opportunity to engage in some pastimes and activities, which included in-house events as well as going out in small social groups.

People were able to have their complaints investigated without bias and they were encouraged to maintain healthy relationships. People felt they were in control of their lives.

Is the service well-led?

Good

The service was well led.

People had the benefit of a well-led service of care, where the culture and the management style of the service were positive and the checking of the quality of the service was effective.

People had opportunities to make their views known and people were assured that recording systems in use protected their privacy and confidentiality. Records were well maintained and were held securely in the premises.

Magnolia House

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 of Magnolia House took place on 3 and 5 February 2016 and was unannounced. The inspection was carried out by one Adult Social Care inspector.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC), from speaking to the local authorities that contracted services with Magnolia House and from people who had contacted CQC, since the last inspection, to make their views known about the service. We had also received a 'provider information return' (PIR) from the registered provider. A PIR 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 spoke with eight people that used the service, three relatives, the registered manager and a company director. We spoke with four staff that worked at Magnolia House. We looked at care files belonging to five people that used the service and at recruitment files and training records for six staff. We looked at records and documentation relating to the running of the service; including the quality assurance and monitoring, medication management and premises safety systems that were implemented. We looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff at meal times. We looked around the premises and saw communal areas as well as people's bedrooms. We were able to ask some people for their permission to do so, but the service was so large that it was impossible to ask everyone. Those people we spoke with in their bedrooms gave their consent to enter their private space.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Magnolia House. They explained to us that they found staff to be "Nice girls who treat me well" and "The staff are good people who treat us well. If they were to harm any of us we would tell the manager." People also said, "I feel quite safe here, no one ever speaks rudely or unkindly", "I feel safe living here" and "The home is quite secure and there are always staff on hand to check things are okay." Relatives we spoke with said, "I know I can always go to the manager if there are any concerns about staff, but I have always found staff approach to be polite and kind" and "I have no concerns about my [relative's] safety here at Magnolia."

We found that the service had systems in place to manage safeguarding incidents and that staff were trained in safeguarding people from abuse. Staff demonstrated knowledge of what constituted abuse, what the signs and symptoms of abuse might be and how to refer suspected or actual incidents. Staff said, "I've done safeguarding training and would refer any concerns to the local authority safeguarding team, if need be" and "I would pass any issues to my senior staff or the manager."

We saw evidence in staff training records that staff were trained in safeguarding adults from abuse and we saw the records held in respect of handling incidents and the referrals that had been made to the local authority safeguarding team. We discussed these with the registered manager and one of the service's directors. These corresponded with what we had been informed about by the service through formal notifications to us, which numbered 11 safeguarding referrals in the last year. This was a little over what was expected in respect of the number of referrals for a service of this size.

However, discussions showed that where the safeguarding team had not needed to investigate incidents and passed responsibility to the registered provider to investigate, the registered provider had addressed a range of different issues. These were all investigated and responses given to the local authority and to the people concerned that used the service. The service had learnt from mistakes and changes has been implemented, for example, staff had received updated training in moving and handling in one instance, equipment used by the person that used the service had been changed in another instance and policy and protocol had been renewed in a third.

Staff training in this area, systems in place to manage safeguarding and practices followed to reduce risks and changes in policy and protocols ensured that people that used the service were protected from the risk of harm from abuse.

We spoke with the registered manager, a director and the staff about whistle blowing and how this was handled. The registered manager and director considered whistle blowing to be positive and a means of learning about shortfalls in the service that required solutions being found to resolve them. Staff told us they would not hesitate to whistle blow to us regarding issues of concern about the service or to the registered manager about other inappropriate practice, for example, staff approach and care. We received four whistle blowing referrals in the last year, which gave us cause to consider the service at risk in respect of incidents. These were all passed to the registered provider to address as they related to inappropriate lifting

and handling of people by staff, slow response to people's requests for support, staffing shortages and inappropriate dining facilities. We also passed some details to the local authority quality development team who visited as part of their quality monitoring, but they told us they found no serious concerns.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. One person's care plan stated, '[Name] joins in with the church service.'

We saw no evidence to suggest that anyone that used the service was discriminated against. One example told to us by a visitor was that a relative had received care shortly after admission, from a staff member of the opposite gender and disliked this. It was mentioned to the registered manager. Instruction was therefore given to all staff and this was recorded in the person's care plan, to ensure only staff of the same gender attended to them. The visitor said this had been the case ever since.

We saw that people had risk assessment documents in place in their care files to reduce their risk of harm from, for example, falls, poor positioning, moving around the premises, inadequate nutritional intake, weight loss, dehydration and the use of bed safety rails. These common areas of risk, where relevant to each individual, were assessed on the form, but other areas of risk very pertinent to individuals were also individually risk assessed, for example, from having arthritis or from spending a lot of time alone in one's bedroom. Therefore each person's risk assessment was different. Family members we spoke with told us, "[Relative] had some falls last year and the staff implemented a risk assessment to help reduce them. They saw the GP and were referred to the 'falls team' at the council" and "I know there is a risk assessment in place for [relative's] nutrition and skin integrity and there may well be other areas included now."

We saw that the service had maintenance safety certificates in place for utilities and equipment used and these were all up-to-date and there were contracts of maintenance in place. We saw that the passenger lift and personal lifting equipment was checked under LOLER regulations (LOLER is the Lifting Operations and Lifting Equipment Regulations 1998). We also saw people's personal safety documentation for evacuating them individually from the building in the event of a fire. These were in the form of 'personal emergency evacuation plans'. All of these safety measures and checks meant that people were kept safe from the risks of harm or injury.

We found that the service had accident and incident policies and records and logs in place should anyone living or working there have an accident or be involved in an incident. Records showed that these had been recorded thoroughly and action had been taken to treat injured persons and prevent accidents or incidents re-occurring. Where necessary accidents were reported under RIDDOR (Reporting Injuries, Diseases and Dangerous Occurrences Regulations). People were referred to the local authority 'falls team' when necessary, hazards were removed and there were details of changes in the premises fittings, for example, where it was shown that these had been the cause of an accident.

When we looked at the staffing rosters and checked these against the numbers of staff on duty we saw that they corresponded. The majority of people we spoke with and their relatives told us they thought there were enough staff to support people with their needs. One relative said, "I see a lot of staff floating around and there is always someone to ask advice from." One person that lived at Magnolia House said, "The staff work very hard, they work long shifts and are on their feet all day, but never complain. However, they are still there when you need them." Staff told us they covered shifts when necessary. One staff said, "Sickness is the hardest to cover, especially when staff only give a couple of hours' notice or when they say they have

been given a hospital appointment last minute, but we usually manage." Staff said they sometimes had sufficient time to carry out their responsibilities and speak socially to people, for example, when assisting them with pastimes or activities. We saw that there were sufficient staff on duty to meet people's needs on the two days we visited the service.

However, we received information on two occasions throughout 2015 about there being insufficient staff on duty to meet people's needs and some people we spoke with felt there could be more staff at particular times of the day. We discussed the staffing levels and people's dependency levels with the registered manager and a director and asked how the service calculated staffing hours required to meet people's needs. The registered manager told us they used a dependency tool and assured us, in light of the concerns raised last year that overall staffing levels would be regularly reviewed and amended. They had already been improved on Maple Court as part of a staffing restructure and the activities coordinator on that unit also assisted with care at key times. Management carried out a walk-about several times a day and were also available to assist where necessary. We saw a dependency tool that had been completed in a person's care file and it recorded they were assessed as having a 'high' dependency in respect of their needs. We saw this was reviewed every month. The registered manager was aware of the need to ensure staffing levels were sufficient to meet people's needs. Action taken by the registered provider in response to the concerns: an internal investigation and production of an internal staffing issues report, was satisfactory and no further action was required.

The registered manager told us they used thorough recruitment procedures to ensure staff were right for the job. They ensured job applications were completed, references taken and Disclosure and Barring Service (DBS) checks were carried out before staff started working. A DBS check is a legal requirement for anyone over the age of 16 applying for a job or to work voluntarily with children or vulnerable adults, which checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We saw this was the case in all six staff recruitment files we looked at.

As well as seeing evidence of staff recruitment we also saw that staff files contained evidence of staff identities, interview records, health questionnaires, correspondence about job offers, curriculum vitae and contracts of employment. We assessed that staff had not begun to work in the service until all of their recruitment checks had been completed which meant people they cared for were protected from the risk of receiving support from staff that were unsuitable.

We looked at how medicines were managed within the service and checked a selection of medication administration record (MAR) charts. We also observed some medicines being administered to people that used the service and we asked people if they were satisfied with the way their medicines were managed.

We saw that medicines were obtained in a timely way so that people did not run out of them, that they were stored safely, and that medicines were administered on time, recorded correctly and disposed of appropriately. People told us, "My medication is handled by the staff here, which is fine by me", "The staff are sometimes a bit lax bringing my tablets, but I usually get them in the morning and in the afternoon. I have had my cream run out once or twice" and "I prefer the staff to look after my tablets as I might get mixed up with them." We were satisfied that medication was given on time and creams were in plentiful supply, with very rare occasions where this might not be the case, due to unusual circumstances. Staff told us the general view was that it was preferred that people's medicines were kept under the control of the senior staff or unit managers, for safety reasons. We saw that MAR charts were appropriately completed and signed.
All controlled drugs in the service (those required to be handled in a particularly safe way according to the

Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001), were safely stored and managed. Controlled drug registers were held for each unit and the ones we looked at were accurately completed and signed.

The infection control systems within the service were not fully assessed, but we saw that the premises were clean and hygienic and we determined that effective systems were in place to manage the control of infections. We were aware that the service had experienced an infectious illness in the last year, the premises were closed to non-essential visitors and support and advice was obtained from the Public Protection Agency (PPA). We were informed at the time of our inspection that where necessary people were isolated in their bedrooms in line with the PPA's advice and regular sample checks were undertaken as appropriate, to assess and reduce the spread of infections.

We saw that the service had appropriate personal protective equipment available for staff, used a set of colour coded laundry skips on each unit, provided soap, paper towels, sanitizing gel, bins with lids for waste and ensured all laundry was washed at required temperatures to eradicate infections. The service was clean and hygienic, but some minor unpleasant odours were found in seven of the eighty plus bedrooms available. These were discussed with the registered manager and cleaning staff were appointed to ensure carpets were cleaned at the time of the inspection. The management team were already aware of this and plans were underway to replace some carpets in the next few days.

Good

Is the service effective?

Our findings

People we spoke with felt the staff at Magnolia House understood them well and had the knowledge to care for them. They said, "Staff tell me what is happening when they hoist me and do this competently" and "I think the staff seem to know what they are doing, they know my needs and meet them well." A visitor we spoke with said, "My [relative] came here just under a year ago after showing no motivation for life for about three years and losing their memory in that time. We had to make a quick decision and after looking at a review of Magnolia on the internet we brought them to look round. We decided not to look anywhere else because my [relative] said 'I could like it here'. They came and their wellbeing improved in such a short time. They look like my [relative] again."

We saw that the registered provider had systems in place to ensure staff received the training and experience they required to carry out their roles. A staff training record was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. We saw staff records that also confirmed the qualifications they had achieved. The registered provider had an induction programme in place and we saw the records of staff induction in the files we viewed. The registered manager reviewed staff performance via one-to-one supervision and there was an annual scheme in place, meetings of which were also recorded.

Staff told us they had completed mandatory training (minimum training as required of them by the registered provider to ensure their competence) and had the opportunity to study for qualifications in health care. This corroborated the information we had seen in their files. Some training was provided in-house by employees that had completed 'train the trainer' courses, for example, in moving and handling.

We were told by a director we spoke with that the chairman of the company had completed a degree in dementia studies at Bradford University and that all three company directors, shareholders and the registered manager were trained to carry out dementia care mapping assessments on people living with dementia. This exercise had been carried out for five of the people that used the service who were living with dementia, to enable a better understanding of their needs and therefore ensured their care plans could be accurately updated. This showed that the registered provider was dedicated to enhancing the quality of care and wellbeing for people living with dementia.

We saw that communication within the service was good between the management team, the staff, people that used the service and their relatives. People that used the service and their visitors were heard asking staff for information and we heard them exchange details so that staff were aware of people's immediate needs and visitors were aware of people's current situations. People said, "I only have to speak to one of the staff and the information is passed to the manager or to my relatives if that is what I want" and "We get to know what is going on in terms of activities, changes in staff and so on." Visitors we spoke with said, "Communication is very good, I am contacted if [relative's] situation alters" and "If I need to know anything about my [relative's] care or their needs, I just ask the staff. Serious issues can be discussed with the manager or a unit manager."

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 interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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 found that seven people had DoLS in place, where this was considered necessary to protect them against unlawful restrictions on their liberty. Documentation was in place and was reviewed accordingly.

We saw that people gave staff their consent to receive care and support by either saying so or by agreeing to accompany them and agreeing to accept the support offered. When we asked staff about their view of obtaining consent they explained the importance of this and told us they always asked people what they could help them with, offered people choices about their daily routines and waited for a response before carrying out support to people. We saw that care plans had been signed by people, where possible, and by their representative where they were unable to sign. There were some documents in people's files that had been signed by people or relatives to give permission for photographs to be taken, care plans to be implemented or medication to be handled on their behalf, for example.

People had their nutritional needs met by the service because people had been consulted about their likes and dislikes, allergies and medical diets and the service sought the advice of a Speech and Language Therapist (SALT) when needed. The service provided three nutritional meals a day plus snacks and drinks for anyone that requested them, particularly at supper time. Fluids were provided to people all through the day and we saw staff refreshing water and juice jugs in people's bedrooms. The two main meals of the day; lunch and tea, were provided using an external catering company that produced nutritionally balanced meals and delivered these in individually frozen portions, which staff then heated according to specific temperatures and times in specially designed mobile ovens. People were given their breakfast and supper by the staff who ensured people received these shortly after being assisted to get ready for the day or ready to retire at night.

A cook was employed to carry out any baking that was required and to prepare choice alternatives of sandwiches, buffet teas and snacks. The cook also ensured people were involved in choosing meals by asking them to sample new meals on offer by the catering company and by asking people about their choices for the day. There were nutritional risk assessments in place where people had difficulty swallowing or where they needed support to eat and drink. Menus were available for people to see what was on offer and people told us they were satisfied with the meals provided. Their comments were varied and included, "I really like the meals, they are tasty", "I think the food is all right, there is plenty", "Food comes from an outside caterer but I find the meals are good and nutritious", "I am not that keen on the choices they are a bit monotonous", "I am not that fussed about the meals, though there is always plenty of veg and the meat is usually tender" and "We get plenty to eat, two courses at lunch and three at tea time."

A visitor told us, "Meal provision changed over to the current system not long after [relative] came here. Some look good, but others don't take my fancy. However, [relative] says they enjoy the food" and "I never hear my [relative] complain about food, in fact they say they eat everything offered."

We saw that people had their health care needs met by the service because people had been consulted about their medical conditions and information had been collated and reviewed with changes in their conditions. For example, we saw in care plans that one person's medical conditions were listed and there was instruction to staff on how to support them with these. Another person was reported as having had a spell in hospital and there was instruction on what care they needed now they were home. We were told by staff that people could see their GP on request and that the services of the District Nurse, chiropodist, dentist and optician were obtained whenever necessary. Health care records held in people's files confirmed when they had seen a professional, the reason why and what the instruction or outcome was. We saw that diary notes recorded where people had been assisted with the health care that had been suggested for them.

We saw that the premises were well maintained and extremely suitable for providing older people with a comfortable environment. Facilities included several lounges, garden courtyards and an entrance area where people could sit, meet up and help themselves to a hot drink if they wished in the entrance. There was one very large dining room with a conservatory added to it to make a large sitting area on Cedar Court as well another dining area on Lavender Way. These communal areas were accessible to anyone that used the service, barring those on Maple Court. People had access to a hairdressing salon and there was a small shop with toiletries, cards and sweets in the reception area. Bedrooms were uniformly decorated but they were all personalised with people's small items of furniture, personal possessions, bedding, photographs, paintings and ornaments.

For those people that used the service who were living with dementia, approximately one third of the whole group, we found that their environment in Maple Court was fitted with appropriate signage in respect of toilets and bathrooms and their individual bedrooms. Peoples' bedroom doors were of different colours and had symbols on them to identify which was their bedroom. Carpets and décor were plain and therefore did not confuse people. There was one main lounge and one main dining room on Maple Court, a memorabilia room used for reminiscence, craft work and film viewing and an enclosed safe garden where people could access the outdoors and fresh air in the better weather without the need for constant supervision.

Good

Is the service caring?

Our findings

People told us they got on very well with staff and each other. They said, "Most of the staff here are good and we have a laugh and a joke with the young ones. I always get the help I ask for", "The staff are very willing and very caring", "I see one of the staff every two hours or so as they come in to check on me, because I am so tired these days I don't want to go to the lounge any more. The staff are very helpful when they visit me. One of the cleaners that come in is a breath of fresh air, always happy" and "The staff are so caring they go out of their way to do exactly what you want."

Visitors we spoke with said, "The approach from staff is very helpful. My [relative] struggles with buttons and the staff are most helpful, even the cleaner will help. My [relative] tells me they get on well with all of the staff and that they even get the odd kiss. [Relative] tells me they feel very much at home here and that one of the seniors is like a third daughter to them" and "I think the staff are very caring, they always offer to help [relative] and when [relative] asks them for anything it is carried out without any fuss."

We saw that staff had a pleasant manner when they approached people and we heard staff interacting well with people and showing interest in them, as staff knew people's needs well. Some of the staff had been employed at Magnolia House for many years, but others came and went. The registered manager and director were polite, attentive and informative in their approach to people that used the service and their relatives, but concentrated all of their time on managing the service, it being so large. All care responsibilities were delegated to care staff and seniors, and while unit managers provided hands-on care when necessary much of their time was spent managing the four units in respect of people's daily needs.

We saw that everyone had the same opportunities in the service to receive the support they required, were spoken to by staff in the same polite way and yet were treated as individuals. Their particular needs were met according to people's personal wishes. Care plans, for example, recorded people's individual routines and preferences for personal care, social activity and maintaining relationships, and while staff followed these plans we saw that staff also encouraged independence of thought and deed, so that people could decide things for themselves whenever possible. Staff enabled people to be in control of their own lives and choices. Care plans also recorded people's differing food preferences and how people wanted to be addressed and we saw that staff knew these details and followed them accordingly.

We saw that people who used the service had their general well-being considered and monitored by the staff who knew when to seek external medical support from healthcare professionals. Staff also knew when people were feeling low or unhappy by observing changes in their mood, which meant that people were not left without support or a smile from staff for too long and had their spirits lifted.

People were supported to engage in pastimes they had been interested in in younger life, which meant they were able to continue some of these and therefore control some aspects of their life in care. This helped people to feel their lives were worthwhile, busy and occupied and aided their overall wellbeing. For example, one person told us how they had always read extensively and completed crosswords and puzzles. They said this was still important to them, they had access to books, newspapers and puzzle books and

sometimes preferred this to mixing with other people. We found that most people were experiencing a satisfactory level of well-being and were quite positive about their lives. Some found it difficult to adjust to being in care and losing elements of their independence, but staff approach was such that it helped people to feel they were still in control of their lives, choices and decisions.

While we were told by the management team that only one person living at Magnolia House was without relatives or friends to represent them, we were told that advocacy services were available if required and the one person concerned had support from a solicitor. Advocacy service information was provided in leaflet form and held on the notice boards in Magnolia House.

People we spoke with told us their privacy, dignity and independence were always respected by staff. People said, "Staff are discreet with my personal details and never embarrass me when they provide personal care" and "I think my privacy and dignity are well respected. No one knows my business, except the staff." We saw that staff only provided care considered to be personal in people's bedrooms or bathrooms, knocked on bedrooms doors before entering and ensured bathroom doors were closed quickly if they had to enter or exit. All of this meant that people were never seen in an undignified state of undress. One visitor we spoke with said, "My [relative] has privacy in their bedroom and the en-suite helps greatly. Their dignity is maintained because staff are careful."

When we spoke with staff about this they said, "Dignity is important. We never provide care in a public area and always try to keep people covered when receiving personal care" and "I've seen care done badly at another place and would never allow that to happen here. People are spoken to politely, their permission is obtained and staff are discreet in all things."

We saw that where people were in need of 'end of life' care staff accessed support from the district nursing services, had revised plans of care in place for personal care, nutrition, hydration and medication, liaised with relatives at every opportunity and ensured people were accompanied as much as possible. Staff followed people's end of life wishes where known and when this was recorded in their care files.

Good

Is the service responsive?

Our findings

People we spoke with felt their needs were being appropriately met. They said, "The staff help with whatever I ask them to. They know what support I need, minimal really, but everything is written in my care plan, so my needs are well met" and "I have physical needs in the main and need help with getting a bath and of course the cooking of my meals. Everything here is done for you as you need it. I think the staff meet my needs very well. I would just like to have more independence with my mobility."

We looked at five care files and found that the care plans were person-centred and contained information under several areas of need to instruct staff on how best to meet people's individual needs. One care plan was out of date in respect of the person's mobility, skin integrity, their nutrition and personal care, as they were now receiving care in bed, and it wasn't until we got to the end of the file that we saw there was a one page review of needs which related to their end of life care. We discussed this with the registered manager and they agreed that the latest details regarding the person's care needs, which were recorded on the one page profile, ought to have been written more specifically in line with the end of life care they required.

The care plans we saw contained risk assessment forms to show how risks to people were reduced, for example, with pressure relief, falls, moving and handling, nutrition and bathing. There were also risk details covering personal issues. We saw that care plans and people's risk assessment forms were reviewed monthly or as people's needs changed.

There were activities held in-house with staff and an activities coordinator was employed to facilitate these. People had individual activity records in their files. People told us they sometimes joined in with entertainers that visited and played bingo or joined in with quizzes held in the lounge. We understood from the registered manager that weekend and seasonal events were held where family, friends and members of the local community were invited to join in with strawberry tea parties, summer fetes, a barbeque and the Christmas pantomime. The activities coordinator also worked at weekends and in the evening to facilitate theme nights: curry night, film night, or a pyjama party. People said, "We sometimes go the theatre or cinema, in fact we are going to see the new 'Dad's Army' film soon" and "I am going to listen to the entertainer shortly, he plays the piano without music and is very good." We saw that people in Maple Court were tidying up after a craft session so that lunch could be eaten and staff told us people in Maple Court liked to sing and dance to music. We saw that people also had newspapers, magazines and puzzle books brought in for them or delivered. People watched their own televisions and listened to music in their bedrooms or they could do this in the lounges as well. A visitor we spoke with old us, "My [relative] goes to the pictures and the theatre with staff, and they enjoy lots of banter with other people and the staff as well."

We saw that the service used equipment for assisting people to move around the premises and that this was used well in response to meeting people's needs. People were assessed for its use and there were risk assessments in place to ensure no one used it incorrectly. People we spoke with felt there had been a lack of hoisting equipment available recently though and said they often waited for staff to locate a hoist in some other part of the building or on a different floor. When we asked staff they told us one hoist had been broken and so they were one short for a while, that a new one had been purchased, but was still waiting to

be commissioned and so people were having to wait a little longer than usual. The registered manager confirmed this as well, but also told us that there were sufficient hoists to ensure one was available on each unit in response to meeting people's needs. We saw that a 'standaid' hoist was stored in one of the shower rooms on Cedar Court and another was seen in a bedroom on Lavender Way. Staff told us that certain people used a 'rotunda' mobility aid to assist them with their mobility. People had their own hoist slings which were labelled.

Bed rail safety equipment was in place for some people, which had been risk assessed and this was used well in response to meeting people's needs. Where bed safety rails were considered unsuitable we saw that people were assessed to have safety mats on the floor by their beds, which responded to their needs in a different way. Where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence. All equipment in place was there in response to meeting people's needs and to aid people in their daily lives to ensure independence and effective living, but not unless people wanted it and, where necessary, they had been risk assessed to use it.

Some people preferred to remain in their bedrooms and not mix with others unless at meal times or to join in with entertainment. These people were visited throughout the day by staff checking they didn't need anything. Some people spent some of the day on bed rest and when appropriate people had all of their personal care needs met while constantly in bed. This meant staff checked on them at regular intervals and assisted them with positional changes, drinks and food. These people had monitoring charts, for nutritional intake and changes in their position, that recorded when staff had supported them and we saw these were completed appropriately.

Staff told us that it was important to provide people with choice in all things, so that people continued to make decisions for themselves and stay in control of their lives. People had meal choices, chose where they sat, who with, when they got out of bed or went to bed, what they wore each day and whether or not they went out or joined in with entertainment and activities. People's needs and choices were therefore respected.

People were assisted by staff to maintain relationships with family and friends. Staff who 'key worked' with people got to know family members and kept them informed about people's situations if people wanted them to. Staff also encouraged people to receive visitors and telephone them on occasion. Some people told us they liked to write to family and friends that lived many miles away and we saw two people doing this. Staff spoke with people about their family members and friends and encouraged people to remember family birthdays, by helping them send cards and gifts.

We saw that the service had a complaint policy and procedure in place for everyone to follow and records showed that complaints and concerns were handled within timescales. Compliments were also recorded in the form of letters and cards. The service ensured that every person that used the service and their relative had an individual postcard they could complete, seal and send at any time to the registered provider to say whether or not they were satisfied with the service. The postcard included questions on care, dignity, management, cleanliness of bedrooms, activities, security, safety and value for money. Most people we spoke with told us they knew how to complain, but one person said they did not, though they also said they could talk to several of the staff who they felt they knew well or go and speak with the registered manager in the office.

Staff we spoke with were aware of the complaint procedures and had a healthy approach to receiving complaints as they understood that these helped them to get things right the next time. We saw that the service had handled four complaints in the last year and complainants had been given written details of

explanations and solutions following investigation. All of this meant that the service was responsive to people's needs.

Good

Is the service well-led?

Our findings

People we spoke with felt the service had a pleasant, family orientated atmosphere. Staff we spoke with said the culture of the service was, "Very caring, knowledgeable" and "Happy."

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post, who had been the registered manager for four months.

The registered manager and registered provider were fully aware of the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistake made). We saw that notifications had been sent to us over the last year and so the service had fulfilled its responsibility to ensure any required notifications under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been notified to the Care Quality Commission.

We found that the management style of the registered manager was open and approachable. Staff told us they could express concerns or ideas any time through the chain of responsibility; seniors, unit managers and then the registered manager and that they felt these ideas were always considered.

Magnolia House has been a registered service for over 20 years and has grown in size over that time. The service had written visions and values and a 'statement of purpose' and 'service user guide' that it kept up-to-date (documents explaining what the service offered). These contained aims and objectives of the service as well. We were told that all three documents were due to be reviewed by one of the directors. The main visions of the service were 'putting the vulnerable first' and 'making new memories' as displayed in the reception area of the premises. The main values were 'warmth, safety, quality of life, independence, dignity, choice and fulfilment.'

We looked at documents relating to the service's system of monitoring and quality assuring the delivery of the service. We saw that there were quality audits completed on a regular basis and that satisfaction surveys were issued to people that used the service, relatives and health care professionals.

The service had an annual plan for carrying out audits, which were completed monthly or quarterly using portable electronic devices. They included checks on,, for example, personnel files, the environment and safety of the premises, health and safety systems, housekeeping, infection control, the kitchen facilities, nutrition and feedback from people about food, meal time practices, views of people about the service and care plans. There were audits carried out on other areas also.

We saw daily quality audits carried out on the daily logs completed of people's care, so that unit managers and senior staff were keeping up to date with, for example, blood test results, visits from GPs and personal care needs. A print out of an audit that identified an issue was given to unit managers and senior staff to ask for an explanation of what was done and when, to ensure all care issues were followed up. This had to be returned to the registered manager, with the explanation within two days. This was a way of monitoring the volume of missed actions, following care and health care given to people, that should have been carried out

and was not. We were told by the registered manager and director that it worked well and staff were now used to it being implemented whenever follow up action to care given was identified as missed. They said it kept staff focussed on their tasks and responsibilities and ensured actions were not missed for more than two days.

We saw some returned satisfaction surveys that had been given out to people and their relatives in October 2015 and were told that the next ones to be sent out would be to all stakeholders in March 2016. There was evidence that surveys had been analysed and the collated information was seen on a summary spread sheet. Action plans were devised to show how improvements were to be made following analysis of the comments received. The registered manager and director told us that new satisfaction surveys were soon to be issued and that analysis of the feedback would be incorporated into the service's newsletter in future.

People we spoke with said, "I completed a satisfaction survey about a year ago", "I cannot remember filling in a survey, but I could have" and "I have completed surveys in the past and should be getting one soon, I believe." A visitor we spoke with told us, "I was asked to complete a satisfaction survey and I also helped my [relative] to complete one, but we've had no feedback yet as far as I am aware." We asked people about other ways that the service sought their opinion and one person said there were none, although they told us they mentioned an issue to one of the staff and this was dealt with. However, other people said there were meetings they could attend, they could speak to any member of staff or the registered manager anytime and they could have a review meeting to discuss problems or changes in their personal care needs.

We saw evidence of 'resident' meetings, staff meetings and 'dignity' meetings. Some meetings were chaired by the activities coordinator, but staff meetings were chaired by unit managers or the registered manager. Meetings, daily conversations and formal satisfaction surveys were some of the ways the service sought people's views about service provision and care that people received.

The service kept records on people that used the service, staff and the running of the business that were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held.

We found that Magnolia House was a very large service with constant changes in the numbers and needs of people that used it. The service could accommodate a maximum of 96 people. There were often changes in staff, with 83 employees at Magnolia House and more than 90% of them employed on a part time basis. This made for a difficult service to manage. However, there was a clear management and staffing structure in the service and the registered manager and a company director shared the managerial role, each having different responsibilities.

The registered manager was responsible for recruitment decisions, maintaining some budgets and ensuring relationships with other organisations were maintained, for example. They had unit managers that they could pass responsibilities to, for example, the producing of staff rosters and covering shift vacancies. However, we found that the registered manager knew about people's issues and needs and was able to tell me something about every one of them that used the service. The company director was responsible for issues relating to health and safety, auditing and the premises, for example. Overall the service was well-led.