The Gloucester Charities Trust

Magdalen House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

This unannounced inspection took place on 14 and 15 December 2016.

Magdalen House Nursing Home provides residential and nursing care for up to 30 older people. When we visited 27 people were accommodated. The home is purpose built over two floors and a passenger lift provides easy access to both floors. There are two communal rooms, one on each floor, where people can dine and seat comfortably in easy chairs. There is a small day centre people can access adjacent to the home. There are well tended gardens and parking at the front of the home.

There was no registered manager. 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. The current new manager was in the process of applying to become the registered manager.

There were some minor shortfalls in the administration of medicines and we have made a recommendation about the management of some medicines. However these issues had been identified through their own quality assurance processes. People and their relatives told us they felt safe in the home. Staff knew how to keep people safe and were trained to report any concerns. People were supported by staff that were well trained and had access to training to develop their knowledge.

People had a choice of meals. We observed one meal time and people's experience could be improved. There were insufficient staff to support people in the dining room. When people required assistance with their food in their bedroom staff supported them and gave them time to enjoy their meal. People had a range of activities to choose from which included exercise classes, arts and crafts, musical entertainments and weekly trips out in the mini buses. There were links with the local community at the adjacent day centre and a church social club.

The current care plan records were not as person centred as they could be but we could see the new care plans were an improvement. Each day one care plan was reviewed and the person would be included in the 'Resident of the Day' review where all aspects of their care were looked at.

The manager, compliance manager and the Chief Executive Officer monitored the quality of the service with regular checks and when necessary action was taken. Staff felt well supported by the manager. Staff meetings and resident/relative meetings were held and they were able to contribute to the running of the home.

People were treated with kindness and compassion and we observed staff engaged with people in a positive way and they were caring when they supported them. Relatives felt welcomed in the home and told us the staff were kind.

People were able to make some choices and decisions and staff supported them to do this. Staff knew what people valued and how they liked to be supported. People's care was regularly reviewed. External healthcare professionals supported people when required and they were well supported by their GP.

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 is safe

People's medicines had not been managed safely but recent audits had addressed the minor issues to ensure treatment was effective.

People were safeguarded as staff were trained to recognise potential abuse and to report any abuse.

People were protected against the risks of harm and injury as accidents and incidents were closely monitored and action was taken to minimise any further risks.

People needs were met by sufficient staff who had been thoroughly checked during their recruitment.

Is the service effective?

Requires Improvement

The service was not always effective.

People's dietary requirements and food preferences were met for their well-being. Their mealtime experience could be improved with regard to deployment of staff.

People were supported by staff who had completed their training and regular updates. Individual staff supervision meetings were completed regularly to monitor staff progress and plan additional training.

People made most of their daily decisions and where they were unable to they were protected by the Mental Capacity Act and decisions were made in their best interests.

People had access to social and healthcare professionals and their health and welfare was monitored by them.

Is the service caring?

Good

The service was caring.

People were treated with compassion, dignity and respect.

Staff treated people as individuals and positively engaged with them.

People bedrooms were personalised with their own mementoes.

Is the service responsive?

Good

The service was responsive.

People mainly had personalised care plans and improvements were underway to ensure they were more detailed and person centred.

People took part in activities, trips out and had individual engagement with staff..

Complaints were investigated and responded to appropriately.

Is the service well-led?

Good

The service was well led.

The home was managed well and people and staff were well supported.

The manager was accessible to staff and people and had made improvements to benefit people.

Regular quality checks ensured that people were safe and improvements were made.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

Magdalen House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 December 2016 and was unannounced.

The inspection team consisted of one adult social care inspector and a specialist dementia adviser.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with three people accommodated, three relatives, the manager, the CEO, three nurses, one team leader and two care staff, an activity coordinator and two catering staff. We looked at six care records, three recruitment records, medicine administration records, staff rosters and quality assurance information. We contacted a GP practice and social and healthcare professionals that visited the service to obtain their view of the service.

Good

Is the service safe?

Our findings

There were mostly safe medicine administration systems in place and people received their medicines when required. There were some minor areas for improvement, for example completion of topical cream charts and ensuring the medication administration record (MAR) reflected any changes however recent daily medicine audits had helped to ensure these had already been addressed. We recommend that the service consider current medicine guidance from a reputable source to update their practice in medicine management to ensure it is robust.

There were protocols for staff to follow when medicine was prescribed 'as required'. This enabled all staff to make the correct judgement of when to administer them. Medicines were safely stored. Dates of when medicines not on the monitored dosage system were opened were recorded on the items inspected. This enabled staff to discard them within the appropriate time for their efficiency. Any signature administration gaps were explored when staff completed the new audit of the MAR charts three times a day. One staff member told us any gaps in staff signatures on the administration records were followed up quickly to ensure people had their medicine. One person was allergic to a large number of medicines and this was recorded in the care plan and on the MAR. Each person had a six monthly medicines review by their GP and additional reviews when required. The provider's information told us the staff had medicines training and observations of their competency.

People were protected against the risks of potential abuse. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. People told us they felt safe in the home. Staff understood their safeguarding responsibilities and completed annual safeguarding training. They explained what they would do to safeguard people by reporting any incidents to the manager or the local authority safeguarding team. One person told us "I feel safe, the staff are kind". Two relatives told us they felt it was a safe place and they were always kept informed about any changes. There were clear policies and procedures for safeguarding people which included 'whistle blowing'. Whistle blowing is a term used when staff report an allegation of abuse by another staff member. A healthcare professional told us they had no concerns about people's safety.

People had individual risk assessments for their personal safety in the care plans. Individual risks were identified and minimised to maintain people's freedom and independence. The care plans had clear risk assessments for people, for example; falls and moving and handling. The risks were reviewed monthly and any changes were noted and action taken to minimise risks and deterioration in health and wellbeing. Risk Assessments in the records we looked at were up to date and followed through into care plans. One staff member told us about one person who was living with dementia. They told us, "The person becomes very anxious so we do things slowly. We use the full hoist as they can't weight bear." They told us, "They are losing weight so we assist them with …….. [A complimentary food drink]". The person's food and fluid taken had been recorded on their intake chart.

People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. Any unexplained bruises were investigated and possible causes recorded. The

manager looked at preventative measure after each accident. Accidents and incidents were recorded well and audited monthly. The compliance manager and the CEO representing the provider investigated further any person who had sustained three or more falls. One person had been referred to an occupational therapist after a recent fall.

There was a comprehensive maintenance programme to help ensure the service was safe. Safety issues identified by staff were dated and it was clear when maintenance issues were scheduled and completed. The maintenance staff had completed a monthly health and safety compliance check list which included all areas and installations. We looked at the September 2016 checklist. Actions required were recorded for example shower heads were due to be cleaned. The dates of the latest checks were recorded for example the bi- monthly passenger lift last check was recorded as 29 August 2016. Fire safety risk assessment had been completed in February 2016 and all other weekly and monthly fire safety checks had been completed as required. A contractor had completed checks for Legionella disease in the water system and remedial work was completed in 2015. Water checks were also completed weekly by the maintenance team. The equipment compliance check list informed us that wheelchairs, beds and hoists had been serviced in August 2016. The fixed wiring identified as required in the September health and safety compliance checklist had been completed when we visited.

There were sufficient staff to meet people's needs. The new manager told us they had assessed people's needs by knowing them well and planned to use a dependency profiling tool to ensure the assessment was correct. The last dependency assessment based on people's care needs was recorded in September 2016 and was usually completed monthly. The manager told us they were careful to make sure they had sufficient staff when people were nearing the end of their life. People had been categorised into low, medium or high dependency needs regardless of their need for nursing care. The provider's information and the manager told us the staff rota was based on higher staff numbers to ensure that any staff absence did not impact on people's care. Most people required two staff to meet their care needs and staff were currently working additional hours to cover for two care staff vacancies. The manager told us they were recruiting for care and kitchen staff. Agency staff had been used but this had reduced in the last six months. Two care staff told us there was enough staff to meet people's needs. One care staff member told us there was enough staff but sometimes they were asked to help in the kitchen when they were short staffed there.

Safe recruitment practices were followed before new staff were employed. Correct checks had been completed to safeguard people and ensure staff were suitable and of good character. The recruitment records we checked were complete. Potential new staff were interviewed and introduced to people in the home. New staff shadowed experienced staff when they started and currently they had begun the induction Care Certificate training over 12 weeks. The Care Certificate provides a framework of training for new staff to a recognised standard to help ensure they provide safe and effective care.

People were protected against the risks associated with infection control. There were infection control procedures for staff to follow and we observed staff using personal protective equipment to prevent cross infection. The home was clean and people and their relatives told us it was always clean. The laundry was organised and clean and the housekeeper explained the travel of the laundry in the room to prevent cross infection. There was no laundry procedure but staff were trained to promote infection control. There was one small area of peeling paint in the laundry which had been identified for maintenance to ensure all surfaces could be wiped clean.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was a detailed business continuity plan which covered emergencies for example, power failure, loss of information technology and adverse weather conditions.

People receiving end of life care would be transferred to hospital and the sister home Guild House across the road would be used.

Requires Improvement

Is the service effective?

Our findings

People had a choice of meals and their dietary needs were met but staff deployment during lunch time meant their dining experience could be improved. We observed people during one lunchtime and there was some waiting for them in the dining room. There was only one care staff member in the dining room for 17 people so meal service was slow. One person waited more than 20 minutes for their main meal. Two people required assistance but didn't have staffs full attention and one person's meal was taken away half eaten without staff asking if they had finished.

We observed a person coughing and gagging and no one came to their assistance so we informed the care staff and they removed the person temporarily from the dining room. There were times when two other care staff came into the dining room. One assisted a person with their meal and the other offered more drinks and removed plates. We noticed some people were waiting to be assisted out of the dining room for more than twenty minutes after they had finished. Some people ate in their bedrooms and their meals were served from a hot trolley on the first floor. Staff were assisting people with their meal at a pace to suit the person and they described what they were eating. Tables were laid with condiments in the dining room and there were a choice of drinks in carafes on each table. Clothes protectors were offered to people.

We spoke with two of the chefs. Both told us about people's food preferences and diets. There was a white board in the kitchen which was updated by care staff from the catering information form. Nurses and team leaders updated the form as required when new people came or people's diets changed. One chef told us they talked to people to find out what they liked about the menu and if they wanted any changes. One person had told the chef they didn't like sprouts so they had made sure they had an alternative. The chef visited people daily to find out their choice for meals. They told us there was always alternatives and all vegetables were fresh. The chef told us they had made an alternative dessert of apple sponge on the day we visited for people living with diabetes. One person told us they had a choice of food and the food was "ok." One relative told us there was a lot of choice for breakfast and they could book a meal in advance to join the person.

The providers information told us each person had a nutrition care plan which looked at their food and fluid needs, including preferences for portion size, likes, dislikes, special diets, modified textures and fortification requirements. People took part in discussions where their views were sought about food. Fortnightly people were able to sample new foods and indicate if they would like them on the menu. Each person had an individual monthly talk with a chef to find out about their food preferences.

People were referred appropriately to the dietician and speech and language therapists if staff had concerns about their wellbeing. Staff followed the Malnutrition Universal Screening Tool (MUST) guidance and weighed people as required to monitor their risk of malnutrition. We found one MUST record was incorrect and the manager agreed staff may need additional training to ensure people were assessed correctly. Where people were at risk of malnutrition they were weighed weekly and had well maintained food charts of what they had eaten and how much. Their food was fortified and they had additional fortified fruit smoothies. Finger food was put in snack boxes and people could snack at night from them. One staff member told us

one person had lost weight and so they had food/fluid charts to record what they had taken and were assisted to drink complimentary food drinks as well.

People were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs. A programme of training to maintain and update their knowledge and skills was in place and staff were informed when their training was due. Much of the training was completed on computer and assessed. Staff had completed a range of training to include dignity and respect, health and safety, moving and handling, infection control, fire safety and food hygiene. The CEO monitored the training schedule daily and a new training coordinator had been identified. Currently there had been a focus on nurses' clinical training where nursing staff had completed for example; catheterisation, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and wound care training. Additional practical training was provided by the day service manager for care staff for example, dementia care and Parkinson's care.

Staff from all departments had a training and development programme where their knowledge and skills were assessed. New staff had an induction and were mentored by experienced staff. Many care staff had National Vocational Qualification (NVQ) or Qualification and Credit Network (QCF) level two qualifications and some were working towards levels three and five. There were development opportunities for staff where they were given lead roles for example nurses were leads on medicines and care planning and team leaders for continence care. The manager told us they were developing additional lead roles for staff. Competency checks for moving and handling had been completed for both day and night staff. We looked at staff competency checks for the MCA where there had been face to face questions and staff answers recorded. This had tested staff knowledge so that their strengths and weaknesses were identified and addressed. Each staff member had a personal training folder and it was their responsibility to complete the training. We found staff training was up to date. One nurse told us they had done lots of training. One care staff member told us their training was up to date.

People were supported by staff that had individual supervision meetings and appraisals. Each staff member had three individual meetings and one appraisal every year. The manager was able to check each quarter which staff were due for an individual meeting on the spreadsheet completed. Staff were given incentives to complete their training and individual meetings on time. One staff member told us they had individual meetings every three months with the deputy manager. They told us the deputy manager was good at the individual meetings and they were able to discuss their training needs and any improvements. A nurse told us the manager had completed their annual appraisal and they had requested three different training sessions in their individual clinical supervision. They told us their requested training had been completed and had included, syringe driver and skin care training.

People were able to make their own choices and decisions about their care and support. We heard staff asking people prior to assisting them. For example staff said, "Is it ok to put this on you to protect your clothes?' "Can I take you back to your room now?" and "Have you finished (meal)"? We observed staff knock on people's bedroom doors and wait for a response prior to entering. One domestic staff member spoke to a person saying, "Here I am, is it ok to clean your room now?" We heard them both chatting together which seemed to be a regular feature for that particular person. One staff member told us about a person living with dementia. They told us the person made day to day decisions as they asked them simple questions. They said the person liked to wash their own face and really enjoyed watching certain television programmes. They also loved company and didn't like being on her own. The staff member told us the person's family visited regularly.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005

(MCA). Staff had completed training on the MCA which 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's mental capacity assessments and 'best interest' records had been completed where required. Their relatives or supporters and the GP were included in the 'best interest' record. Examples of 'best interest' records were for one person to remain at the service and to have all their care provided.

The manager had identified people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. We checked whether the service was working within the principles of the MCA to complete Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The manager had made two DoLS applications where required. One had been approved and one was waiting for approval by the local authority. Best interest decisions were in place and friends and relatives with a Lasting Power of Attorney (LPA) were consulted.

People had access to health and social care professionals. Health and social care professionals visited when required and clear records were kept of the visits. Records confirmed people had access to a GP, dentist, an optician and a chiropodist. One person had recently seen a Heart Failure Nurse Specialist. They had given instructions for the staff to follow and advice about when to give medicines to alleviate breathlessness at night. One person had been supported by a Speech and Language Therapist (SALT). A nurse told us people had good support from a local GP practice that visited weekly and referred to other healthcare professional when it was required.

Good

Is the service caring?

Our findings

People were treated with kindness, compassion and respect. One person said, "The staff always leave my door open at night as I don't like it closed." and "They always knock on the door before coming in." Another relative told us the staff were wonderful and their relative was well cared for. They told us the person was normally happy when they visited. The person told us, "It's ok here" and they told us about all their children and was joking with their relative who was visiting. One healthcare professional told us, "It [the service] always had a very caring staff team who couldn't be faulted in that regard."

We observed staff getting down to a person's level when they were in the lounge to ask them if they wanted their meal, the person only wanted a cup of tea and they provided it instead of lunch. The staff member told us they would try again later to see if the person wanted to eat. We overheard a staff member talking to a person who was anxious, they gently said, "Don't worry, everything is alright." One nurse told us all the staff were caring towards people.

People's rooms were personalised with photographs of their family and friends and some of their own treasured possessions. One relative told us they were able to put up lots of pictures in the person's bedroom to make it their own. The corridors had been named after the streets of Gloucester and there was a lot of interesting information for people and their relatives to see. One relative told us how they liked to see the memorabilia about their home town.

There was a keyworker system which was designed to improve personalised care for people. A key worker is a named member of staff that had responsibility to ensure people's care needs were met. This included supporting them with activities and spending time with them. Staff we spoke with were knowledgeable about people and knew what they liked and the support they needed. One member of staff told us about the individual activities they provided for people which they recorded in the keyworker record. For example hand massages. They said staff were good at providing people with emotional support and always spoke to them reassuringly when they were hoisted.

There was information in the entrance to the home for people and their relatives which included the latest CQC inspection report. There were lots of cards complimenting the staff on the care provided. Relatives had written, "Such great loving care", "You treated her with respect and dignity" and "So cared for and comfortable and content"

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. We spoke with the family of a person nearing the end of their life and they told us, "carers are exceptional" they described how the care was delivered with "dignity, respect, care, kindness and patience." The relatives also praised the catering staff for providing anything the person 'fancied'. They said the person would describe the care themselves as "Everything is lovely." The person's care plan was relevant and provided staff with all the information they needed to give personalised care. The person's nutrition care plan detailed the portion size and consistency of food and to give small

portions often. Fortified foods and complimentary nutritional drinks were given when tolerated. The person was observed while asleep to be very comfortable and peaceful. The relatives had a Lasting Power of Attorney and were able to make decisions with the person.

Good

Is the service responsive?

Our findings

People received personalised care responsive to their needs. The manager had started to improve the care plan records. The current records used were not as person centred as they could be but we could see the new care plans were an improvement. Each day one care plan would be reviewed and the person would be included in the 'Resident of the Day' review where all aspects of their care was looked at. We saw people's relatives had been involved in care plan reviews. There were clear actions for staff to follow in the care plans and the involvement of healthcare professionals was evident to support people's health and wellbeing. A magnetic white board in the secure staff office gave staff an overview of people's needs to provide 'at a glance' information for all staff. For example people were identified when they required wound care. One wound care plan we looked at indicated the wound was well managed and the dressing had been changed as required, every three days. It was clear from the records and the photograph the wound was improving. Reflective practice had identified the person's slippers as the cause of the wound.

One person had seen an auditory specialist about their hearing impairment and had a new hearing aid. Their communication care plan reminded staff to speak clearly, give reassurance and reduce background noise when talking to them. A person living with diabetes independently recorded their daily blood glucose and staff administered their insulin. There was clear information for staff to follow with regard to adjusting the amount of insulin given when required. The person was able to recognise the symptoms when they may need additional food and told the staff. The regular three monthly review visits by the diabetic specialist nurse were recorded in their care plan. One person's anxiety was monitored and assessed with a record of how anxious they were. The GP was informed if their anxiety continued after 'as required' medicine was given.

One person's care plan had recorded recommendations from a heart failure nurse specialist which included medicine to help with the person's breathing during the night, to elevate their legs and raise the head of the bed at night. The care plan was evaluated monthly and had recorded the medicine was not always needed at night but the person had found it effective when they used it. The person's weight was monitored monthly and had fluctuated when they retained fluid in their body. This had been noted and medicine was prescribed to improve the fluid retention.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. We observed the handover from morning to afternoon shift. A nurse gave handover to incoming care staff. Handover was thorough and interactive. For example the nurse was not familiar with a new person but one of care staff was able to give additional information as they were there when the person was admitted. It was mentioned in handover that one person had unexplained bruising. One relative told us they monitor the person well and always informed them if they have a fall. A healthcare professional told us the staff knew people well. They also told us they thought the home was not best equipped to manage mobile dementia people but they were aware of this. There was signage around the home to help people living with dementia but the lift did not have a security key pad to prevent access.

People had a folder in their bedroom called 'Daily Lifestyle Choices' which had a record of their personal background and current preferences. One record we looked at had a clear history about the person with lots of detail about their life and what their preferences were. There was also information in the care plans about people called 'A Bit About Me' which gave a brief insight about the individual.

Some people had wheeled easy chairs to enable them to be easily taken to the dining room and lounges without being hoisted. There was a small lounge on the first floor and not everyone could be accommodated there. We discussed with the manager whether additional space for more easy chairs in the dining room may be needed to accommodate everyone.

People chose what they wanted to do each day and had many activities to choose from which included going out in the mini buses. A weekly activity plan was distributed to everyone based on the feedback from 'resident' meetings. Four activity staff provided 25 hours of activities each week. There was musical entertainment from external providers. One of the activity staff told us they completed individual activities with people. One of the care staff told us they did games with people or had a 'chat' with them. All activities people took part in were recorded. One nurse told us there were lots of activities and trips out for people.

One person told us they went out in a mini bus with other people each week to local towns but didn't usually get out of the bus. They said they enjoyed just driving round the countryside. They told us they had been to Weston-super- Mare and a local garden centre. They also went to chapel services nearby, the adjacent day centre and a church social club. We noticed the lounge had games to play and books from the 1950's people could reminisce with. Most people had rated the activities as good, very good or excellent in the November 2016 satisfaction survey. There was also a monthly Trust magazine which had news, recipes and quizzes for all the people where the Trust provided accommodation. A Trust Christmas party had included people from Magdalen House.

There was a complaints procedure and policy for people and their relatives to see. A minor improvement to add the Local Government Ombudsmen contact details to the procedure was needed. Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been two verbal complaints in the last 12 months. The complaints were investigated thoroughly, verbal responses were given and a record had been kept of the outcomes. Where appropriate an apology was given. Two improvements had arisen from the verbal complaints where a hot trolley had been provided to serve meals upstairs and when people were admitted to hospital the letter H was added next to their name on the magnetic board in the office. This had enabled all staff to know 'at a glance' which people were in hospital. One person told us they had no complaints about the home.

Good

Is the service well-led?

Our findings

The manager had not notified CQC of all safeguarding incidents when people had an unexplained bruise. The manager was fully aware after we discussed the incidents that they should be reported to CQC but we could not assess whether any action they said they would take was sustained. However since the inspection we had received notifications as required from the service.

A healthcare professional told us they were impressed by the new manager who seemed to be getting things organised. For example the nursing staff were more prepared for their visit. Staff and visitors we spoke with told us the new manager was "very organised." Staff felt the manager was approachable and open to suggestions for improvements to the service. Two care staff we spoke with told us there were monthly staff meetings which they felt able to participate in and share ideas for improvements. They told us the new manager has implemented a 'suggestions box'. One member of staff said, "I'm quite impressed with the new manager, she's very organised. She and the deputy are really good." It was evident the Chief Executive Officer (CEO) and the compliance officer had supported the new manager who had a lot of experience in adult social care.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Internal audits were completed monthly and included for example, care plans, infection control and medicines. Shortfalls were identified and action was taken. The monthly provider visit report completed by the compliance manager and a member of the Trustees included input from the CEO. We looked at the October and November report where actions from previous months were followed up as completed. There had been discussion with staff and staffing levels had been looked at in November 2016 and seen as satisfactory. The new kitchen was viewed as clean and better laid out. There was no record of the provider's representatives talking to people in the home. The manager also completed a monthly report to include which audits had been completed and how many deaths and accidents had occurred.

The monthly provider audit report for 2016 – 2017 had started in October 2016 and indicated for example the number of staff individual supervision meetings had been completed, complaints received and MCA and safeguarding training completed by staff each month. Staff sickness and notifications to regulatory and statutory bodies each month had also been identified. Actions and reasons for some figures were recorded but the report was an overview of the service. A more detailed external audit updated in November 2016 detailed where action was still needed and where improvements had been made. For example the reorganisation of the care plans and risk assessments had started and additional care planning training for staff was arranged in January 2017.

There was a five year plan for Magdalen House and it had been updated in November 2016 in year two of the plan. There were five objectives and this included improvement of the existing accommodation. In 2016 lighting had been upgraded and communal areas redecorated. People's bedrooms were being refurbished to include larger televisions and controllable lighting. The laundry was the next planned refurbishment.

People and those important to them had opportunities to feedback their views about the home and quality

of the service they received. People, relatives and supporters were able to comment at meetings and through questionnaires. The Trust's vision, aims and objectives were shared with people, relatives and staff at regular meetings. Meetings were held with all staff, people and their relatives. We looked at the minutes of the whole staff team, the catering team, the night staff and relatives/residents meetings. In August 2016 31relatives and residents attended a meeting and the management of the home was discussed as there had been changes and a new manager was to be appointed. One person said they were unsure who the care staff team leaders were and this had been addressed with staff wearing different badges.

Questionnaires were completed by people and we looked at the 19 responses in November 2016 and the overall results. The majority of responses were positive. People replied they thought the relative/resident meetings held were either 'useful' or 'very useful'. Most people rated the home environment as 'good' or 'excellent', two people rated it 'poor'. Three people had responded 'poor' to staffing levels which was an improvement since the last questionnaire. Where people responded to anything being 'poor' this was discussed with them individually if possible.

Staff meetings highlighted the dining experience still needed to be improved in September and October 2016. A kitchen assistant was to act as host offering people drinks especially if they had to wait for their meal. This didn't happen when we initially observed lunch time during the inspection but two care staff did come into the dining room at one time offering drinks. One person had wanted a different environment as they disliked music and a window open. This was discussed at the staff meeting and the only alternative was for them to return to their bedroom and dine. To dine in the upstairs lounge was not offered. A night staff meeting highlighted the need to improve the night snack boxes made up for specified people, which had been addressed.