Magnum Care Limited

The Magnolia Care Home

Inspection report

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Date of inspection visit:
23 October 2017
24 October 2017

Date of publication:
15 January 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 23 and 24 October 2017. The inspection was unannounced.

At our last inspection in April 2017 the service was not meeting regulations with regard to providing safe care and having systems in place to ensure quality services. We followed up these issues and found some improvements had been made, though further improvements were needed to staff practice, lessening risk to people's safety, having sufficient staffing levels to keep people safe at all times, safe staff recruitment practices, supplying medicines and ensuring people were always supplied with a safe quality service.

At this inspection we found the service to be in breach of Regulations 12, Safe Care and treatment and Regulation 17, Good Governance, of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The Magnolia Care Home provides personal and nursing care and accommodation for up to 38 people. On the day of the inspection the manager informed us that 28 people were living at the home.

A registered manager was in place at the time of this inspection visit but was not managing the service on a day-to-day basis. Another manager had been recruited who provided evidence that she had applied to CQC to become the registered manager in the near future. 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 and associated Regulations about how the service is run.

People's risk assessments did now always include the information staff needed to ensure people received safe care.

Safe care had not always been provided to people. Staffing levels were not sufficient to ensure people were kept safe.

Medicines had not always been supplied to people as prescribed to help them to manage their health conditions.

All staff had not been subject to comprehensive checks to ensure they were safe and suitable to provide care to people who lived in the service.

People and their relatives were not fully satisfied with how the home was run by the management of the service. Feedback was not used to bring about improvements in the service.

Management had carried out audits and checks to try to ensure the home was meeting people's needs, though this system was not effective or robust to ensure that people using the service had their needs met.

People using the service and their relatives said they thought the home was safe. Staff had been trained in safeguarding (protecting people from abuse) and understood their responsibilities in this area.

Systems to ensure that the premises were safe for people to live in were, in the main, in place.

People and their relatives told us that staff were, in the main, friendly and caring. We saw a number of examples of staff working with people in a kind and respectful way.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Risk assessments to promote people's safety were not always in place. Some staff practice did not keep people safe. Staffing levels were not suitably deployed sufficient to keep people safe. Staff recruitment checks were not fully in place to protect people from unsuitable staff. Medicines had not always been safely supplied to people. Staff knew how to report any suspected abuse.

Is the service well-led?

Requires Improvement

The service was not comprehensively well led.

Comprehensive audits were not in place to ensure a safe quality service was provided to people. Relatives views had not been acted on to improve the service. Staff told us that management had not provided support to them in the past, though they were more hopeful of the new management arrangements.

The Magnolia Care Home

Detailed findings

Background to this inspection

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

The inspection was unannounced. The inspection team consisted of an inspector, a specialist adviser, a pharmacy inspector and an expert-by-experience. A specialist adviser is a person who has expertise of the client group of the service. The specialist adviser was a qualified nurse who had expertise of nursing care. A pharmacy inspector is a qualified pharmacist who can judge whether people's medicine has been supplied as prescribed. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert for this inspection had experience of the care of older people with dementia.

We also reviewed the notifications we had been sent. Notifications are changes, events or incidents that providers must tell us about. We reviewed information from commissioners of the service.

We used a variety of methods to inspect the service. We observed how people were supported during individual tasks and activities. We also spoke with 6 people living in the service, seven relatives, the manager, the temporary manager, and three care staff.

We looked at records relating to all aspects of the service including care, staffing and quality assurance. We also looked in detail at seven people's care records.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found that people's safety was not being protected as risk assessments to protect people safety had not been detailed enough, staffing levels did not provide safe care, and staff recruitment processes to protect people from unsuitable staff were not robustly in place. This which meant there was a breach of Regulation 12, Safe Care. The provider submitted an action plan which set out that these issues would be addressed.

People we spoke with told us that, in the main, they felt safe living in the service. However, four people raised concerns about some people living with dementia who had gone into other people's bedrooms or displayed behaviour challenging to the service. They told us that this caused them distress.

One person said, "I feel alright being here but I got grabbed by a lady at lunch the other day and she bruised my arm." Another person told us, "I've been here 10 years so feel safe as they keep an eye on me. But there's a man with dementia who often undresses and sits in my chair and tries on my trousers. I ring the bell and they come and take him away. It used to happen 3-4 times a week but is less now as they keep his door open so he can find his room better."

Relatives were, in the main, satisfied that their family members were safe living in the service. However, one relative said, "They [staff] lift him out of bed by holding his arms. I've not seen them use a hoist." This is unsafe practice as it could injure the person. The manager said she would follow up this issue with staff.

Throughout the inspection visit we saw, in the main, staff ensuring the safety of people. However, we saw two people asleep in the main lounge/dining room who had slumped down in their easy chairs. No support was offered to provide cushions and reposition them to ensure their safety and comfort. When people were provided with hot drinks in the main lounge/dining room, staff gave the cup to them directly. A staff member was aware of a risk of the drink spilling as they warned the person to be careful and not to spill their drink. However, there were no side tables to keep hot liquids safe from people spilling them and potentially injuring themselves. This issue was highlighted in a recent safeguarding investigation by the local authority. This concluded that a person had been scalded by hot liquid when this had been left unattended in the lounge. The manager said these issues would be followed up. This demonstrated that despite the outcome of this safeguarding issue, staff were still putting people at potential risk of scalding from hot liquids.

At the beginning of the inspection the temporary manager stated, "Recording of relevant documentation is not as it should be. Care plans are a challenge; I have been working with the former manager over the last two weeks to improve this."

We discussed this issue with the newly appointed clinical lead nurse (CLN). She stated that there was a considerable amount of work still to do to ensure care plans and risk assessments included all information to provide safe care and meet people's needs. She had established a system so that people with higher dependency needs were given priority to put in place comprehensive care planning and risk assessments.

Many of the risks identified were not accompanied by a management plan and had not been evaluated. There was a risk this impacted on peoples' safety by staff not having essential information to provide safe care,, so care staff had been requested to be specifically vigilant and to report any changes in people's needs to senior staff. The nurse on duty stated staff were carrying this out. She told us, "There are some good carers here. I think what has let them down is lack of documentation, but we have identified training needs where this is concerned."

We saw a care plan and risk assessment for a person with dementia. There was no index to the care plan. This could be an issue if information needed to be found in an emergency. Following the absconding of this person from the home, there was a lack of evaluation and risk management on these issues. There was a referral to a relevant outside agency due to the person's pattern of behaviour. This set out that the recording of behaviour needed to be carried out but there was no evidence of behavioural charts after 30 September 2017. A risk assessment was in place to manage this behaviour which set out for staff not to argue or raise their voice. However, we saw from care records that following an incident in October 2017, a staff member stated, 'Told him no'. We also observed the person trying to get out of a fire door. A staff member went over and said 'No'. The person resisted the staff intervention. These staff actions did not follow the risk assessment and meant the situation could have escalated further. The risk assessment stated that the person needed to be distracted when displaying behaviour that challenged the service. However, there was no information for staff on how they should do this. Daily records in September and October 2017 set out how the person had 'disruptive behaviour.' There was a risk to the safety of the person and other people in the home due to the behaviour not being managed appropriately.

A person with the risk of pressure sores was recorded as being at increased risk, but this had not been evaluated since 13 September 2017. There was no action plan in place or change to the risk assessment although the score for measuring the risk had increased. This meant there was a risk that they did not receive appropriate treatment to prevent pressure sores developing.

With regards to a person on end of life care, the risk assessment on pressure sores was blank even though the score indicated the person was at risk. Records did not reflect any application of barrier creams to prevent pressure areas from developing. The CLN indicated that creams were supplied and a form was being devised so that staff could record applying creams.

A risk assessment for a person identified as being at risk of losing weight stated that the person needed to be weighed every month. We found they had not been weighed in September 2017. This meant, if they had lost weight during this period, timely treatment would not have been provided which was a risk to their safe health. Food and fluid charts were in place but records did not include a target for how much they should drink each day. This meant they were at risk of dehydration. The manager said these issues would be followed up and acted on.

We looked at another care plan of a person with diabetes. This did not indicate what steps staff should take if their blood sugar was below or above a safe level, such as supplying them with specific food or drink to help raise blood sugar levels and the steps staff should take to ensure the person's safety. The manager said these issues would be followed up.

At the last inspection we were concerned that there were not enough staff on duty to ensure people were always safe. On this inspection visit we found six people had been referred to a specialist team due to their behavioural needs. This was because there was a potential risk to them and other people's safety and they needed additional staff supervision.

People told us that items were occasionally taken from bedrooms by other people living in the home. One relative said, "He's [family member living in the service] had his watch, lamp and picture frame all taken by other people wandering in his room. They've found the things in the end but one frame had got broken." This was an indication that a person had not been consistently monitored so that people's possessions were safe.

A staff member said there was not constant supervision of lounges where people sat. They said, "We need more staff. We could then have someone in the lounge all the time." Another staff member told us that there were times in the afternoon period where they had to assist people in their bedrooms. This meant, during these times, no staff had been in the lounge to provide support to people and keep them safe.

We observed lounge areas during the inspection. We found, contrary to the action plan of the provider, that lounge areas, at times, did not have any staff present to ensure people were safe. We witnessed that this happened in the main lounge/dining room on the first day of the inspection visit at 11.30am for eight minutes and at 2.20pm for 12 minutes.

However, staff told us that in the afternoon staffing levels reduced. One staff member said that if staff were needed to provide personal care to people in their bedrooms, lounges could remain unsupervised for up to 30 minutes. This meant people requiring assistance during these times did not have their needs safely protected.

We asked the temporary manager how staffing levels were worked out. She said a dependency tool had been introduced. We were supplied with the dependency tool which did not include essential information such as how staffing levels were able to safely monitor people with behaviour that challenged the service. This contradicted the action plan we received from the provider from the last inspection, which stated lounge areas would be supervised at all times.

Most people told us that they felt staffing levels met their needs. However, a number of relatives thought staffing levels could be improved to enable better monitoring of people's needs.

A relative said, "It (staffing levels) can be upsy downsy and there seems less on at the weekend." Another relative said, "We see them stretched at times." Another relative told us, "I found her [family member] sat in a soiled pad the other day when I took her back to her room - and it must have been like that for ages." And, "I have to prompt them to give her drinks and help her – I shouldn't have to do that."

We spoke with several people who said that staff responded to call bells in a fairly timely manner. However, one person found that a long wait of up to 30 minutes happened on the small number of times. Staff had not apologised and informed the person they would be back as soon as they could. The person said, "They come quite quickly but it can be half an hour. What annoys me is that they don't come and tell me to wait, they just don't come. I ask them to tell me but they don't. So I have to ring again as I get forgotten." When we asked a staff member about the expected time for call bell responses, they said that they had never been asked by management to respond within a certain time.

At the last inspection, we were concerned that staff recruitment practices were not fully in place. On this inspection visit, staff records showed that before new members of staff were allowed to start, checks had not always been made with previous employers and with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character. One staff member did not have a full DBS check in place. We found that one staff member did not have a reference from their previous care employer. Two agency workers did not have references in place.

This meant there was a risk that unsuitable staff were providing care to people.

Two people we spoke with told us that senior staff would sometimes leave them their medication to take unsupervised. There was a risk that they would not take their medicine or that other people would take the medicine instead. This would be a potential risk to people's safety.

Staff said they had received basic training on administration of medicines using the electronic system and three staff had been given more in-depth training. The senior care assistant we spoke with told us she needed more training to add and remove medicines from the system. The manager said she agreed with this view and more training was to be provided.

We observed staff adding an antibiotic onto the electronic medicine system. They struggled to enter the correct formulation as prescribed. She had to receive assistance on this from the temporary manager. We observed that some medicines were not removed from the electronic system when they had been stopped. For example a person had completed their course of eye drops but was had not been removed from the system. There was a risk that people would receive medicines when they no longer were prescribed them.

Administration of medicines on an as needed basis did not have protocols to indicate when this medicine should be supplied. This meant a risk that medicines could be administered incorrectly and inconsistently, potentially being unsafe to people's health.

These issues were breaches of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Safe Care and treatment. You can see what we have told the provider to do at the end of this report.

At this inspection, we saw that improvements had been made with regard to some care plans. Where we saw care plans had been rewritten, information was comprehensively in place. For example, a person had relevant information on how to manage the person's behaviour, continence care, how to recognise pain and wound care plan. It included control measures for risks identified to keep the person safe.

People and relatives said that, in the main, they felt staff kept people safe. One person said, "There seems to be enough for helping us." Another person told us, "I can usually find someone if I need anything."

People said that staff usually handled them competently and gently. We observed pressure mats and pads in use to alert staff to unsafe movement. We saw a member of staff twice encourage a person to stand from their armchair by supporting them.

A relative said, "She's safe, clean and well fed. We've got peace of mind when we're not here." Another relative told us, "I feel he's very safe – the staff are safety conscious of falls and so on." Another relative said, "She [person living in the home] got an alarm pad on her chair in case she thinks she can get up."

We saw that staff had been aware of how to keep people safe. For example, we saw people using walking aids such as frames, and staff providing support to people walking to make sure they were safe. Staff appeared to understand the help that was needed to maintain safety and wellbeing and this was provided when needed.

People told us that staff made the required regular checks and repositioning visits, which were charted in the bedroom. Relatives confirmed they could view and check these records.

Fire records showed that fire precautions had improved since the last fire officer's visit. Records showed that action had been taken to the fire officers requirements. The provider told us that he was going to discuss the condition of the fire alarm system with the fire officer to see whether any improvements were needed. Fire drills had taken place regularly. Fire tests such as testing fire bells and emergency lighting had been carried out regularly.

A procedure was in place which indicated that when a safeguarding incident occurred, management and staff were directed to take appropriate action. Referrals would be made to the local authority. This meant that other professionals outside the home were alerted if there were concerns about people's well-being, and the management did not deal with them on their own.

Staff told us they had never witnessed any abuse towards people living in the service. We spoke with staff about protecting people from abuse. Staff knew how to recognise the signs of possible abuse and their responsibility to report it to the management of the home, or to relevant external agencies if needed.

Some people told us that their medication was always supervised by staff. The manager said this issue would be monitored to ensure this always happened. Relatives told us that they had no concerns about their family members being supplied with their medicines.

We observed medicines administration. The electronic system was signed electronically by staff after the medication was administered and staff stayed with the person until they had taken their medicines. Staff explained what the medicines were and helped people to take their medicine. People received their medicine as prescribed provided when the medicines were accurately updated on the system.

Medicines were securely locked with medicine keys held by the person in charge. The medicine trolley was kept in a locked room but the room temperature was not recorded to ensure medicines were kept at the assessed temperature to ensure their effectiveness. The manager said this issue would be acted on.

We reviewed the controlled drug stock and found the balance to be correct. Liquid medicines were labelled with their date of opening to ensure they were not administered past their expiration date.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, there was a breach of Regulation 17, Good Governance. This was because robust processes were not in place to check the quality of the service. The provider submitted an action plan which stated that a comprehensive quality assurance system would be put in place to ensure the quality of the service.

At this inspection we found improvements had been made, though further improvements were needed. Checking of some quality assurance systems were in place. These included audits on the views of relatives and professionals and checking wheelchairs.

There was an audit of the service undertaken by management a management audit in July 2017. However this did not audit issues in detail. For example, for staff training the audit only referred to training provided to new employees, not whether all staff had proper training in all relevant issues such as moving and handling and medicine administration. The audit had not identified that care plans and risk assessments were not sufficient to keep people safe. The section covering continence care was blank, so this issue had not been audited. A comprehensive medicine audit was not in place. Audits had not detected that some staff practice was unsafe.

The personnel audit of 20 July 2017 did not audit issues in detail. For example, under 'references ', the entry stated 'yes ', meaning no issues were identified. However, we found a lack of references in three staff records we looked at.

There were no detailed audits on relevant issues such as staff training; care plans medicines assessments and staffing levels. This meant that systems and records had not been comprehensively checked to ensure people were receiving good, safe care.

We found that some incidents had not been reported to us, as legally required. For example, it was found that a person had unexplained bruising on 8 September 2017. A person had gone missing from the home on 2 October 2017. A person had been subject to a safeguarding protection plan on 22 June 2017, due to weight loss. This meant we were not able to assess whether the service needed to have an early inspection to check that people were provided with a safe service.

We saw that surveys had been carried out with relative and professionals about the standard of care in the service. For example, in August 2017, the relative surveys stated, "Staff not in the lounge at weekends." The action plan stated that the manager was to discuss this at staff handovers and a staff meeting to rectify it. However, we found a lack of supervision in lounges so this issue had not been acted on comprehensively. Improvements had not been made or sustained as a result of this feedback

Some relatives said they had attended a relative meeting but no minutes were supplied. Issues raised related mainly to staffing levels and the laundry service. Action had not been taken, so relatives did not always feel listened to. One relative said, "I've been to one [relatives meeting] and they talked about the staff

ratio and about the laundry – [it's] still a problem." Another relative said, "I went to one meeting with the old manager but nothing got done. No minutes were seen. We said they were short staffed but she said the ratio was right. We said lounge supervision suffered." This showed that relatives views were not comprehensively listen to and acted on.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Good Governance.

Some people thought the service met their needs. One person told us, "It seems happy enough here." A relative said, "It's a good place and has a different ambience to it since the manager left, so that's good." Another relative said, "It's very cosy and warm feeling." Another relative told us, "It's changed lately and has a better feel."

A staff member told us, "I have seen a few changes for the better already. Some staff I know are thinking of leaving but now there may be a chance that the working environment will improve." Another staff member said, "I have met the new manager and she is lovely. She introduced herself to me and shook my hand."

A staff member told us, "The new managers are approachable. If we have a query we can go to them and they will help." Another staff member said, "The new manager seems friendly. She introduced herself to me and seemed interested in what I was doing."

Another staff member said, ''I am still not sure that I will stay here. One former manager ripped everything apart that we felt was working well, and a lot of staff left. We need continuity and although we all love our work, you need a good leader, someone who you know listens to you." Another staff member said, "I think people are safe here, but I think the problem is the leadership." This staff member also felt that things would improve if there were permanent, and not agency, nursing staff. The temporary manager told us that a full-time nurse had been recruited and would be starting soon.

The nurse on duty said that she had had various concerns relating to a high workload. She told us that she thought the hours at the home were too long, "I worry how the long shifts affect the staff. How alert they can still be or can't be bothered if tired. I think this is one of the reasons why staff have left. Many times I have worked 2-3 hours over my shift end time. Mistakes get made when you are tired. I have been here from 06.45 until 9.30 pm sometimes. The shift is supposed to be 07.30 until 19.30 but you end up staying because you can't get everything done in the time." She now felt more hopeful as these issues had now been recognised by management. The manager said that shift times would be reviewed to ensure staff were able to provide safe care.

We received mixed feedback from people and relatives on the visibility and approachability of management, due to the changes in manager over the past months. However, families spoke more positively about the current situation and morale of staff. One person said, "I see them once a week if I'm lucky. I'd talk to one of the lads (male carers) if I need a word." A relative told us, "I ask one of the nurses if I have any concerns." Another relative said, "I meet up with the owner now and then and chat. The office are always helpful. They like family to be involved. The place has got more connectable now. The last few weeks it seems more organised." Another relative told us, "It was rubbish at first. Poor communication between staff and the manager so things weren't being shared that should be. It's a better atmosphere now she's gone. The majority of the girls are lovely."

People we spoke with told us that they had weekly baths or showers and a daily wash was supplied to people who were in bed. We noticed that not all male residents appeared freshly shaven. Families raised

concerns about the laundry system and clothing being frequently lost or misplaced. This was not an indication of a well led service. The manager stated these issues would be followed up.

Stairways and some bedrooms were in need of a vacuum and dining room floors had not been recently swept. Chairs in the lounges were of fabric and the arms were marked and in need of a clean. We found one chair with a damp patch where a person had sat. The manager said these issues would be acted on.

With regard to improvements needed, one relative told us that they needed to be activities for people. The manager said that an activities organiser was being recruited so that people would have stimulation.

Staff we spoke with told there had been a recent team meeting where they had discussed any changes in the service or any particular issues and concerns with people and their relatives. We did not see evidence of these meetings. The manager said it was her intention to have regular team meetings so that any issues could be discussed with the aim of making improvements to the care provided to people living in the service.

The manager stated that it was her intention to have a more comprehensive auditing process of the services supplied to people.This would help the provider to ensure people were receiving safe, quality care that met their needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not comprehensively kept people safe. Risk assessments to promote people's safety were not properly calculated or detailed enough, some staff practice did not keep people safe, staffing levels did not keep people safe, staff recruitment did not identify potentially unsuitable staff members and medicine was not always safely provided to people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been comprehensively audited and followed up with required action in order to ensure a safe quality service was provided to people.

The enforcement action we took:

A Warning Notice was issued.