St. Vincent Care Homes Limited

Magnolia House

Inspection report

20-22 Broadway
Sandown
Isle of Wight
PO36 9DQ

Tel: 01983403844
Website: www.stvincentcare.co.uk

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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

This inspection took place on the 10 and 17 August 2017 and was unannounced.

At the last inspection the service was rated Good. At this inspection we found the service remained Good.

Magnolia House is registered to provide accommodation and personal care services for up to 46 older people and people who may be living with dementia. At the time of our inspection there were 39 people living at the home. The service is set over three floors accessible by passenger lifts and has a range of communal areas for people to use, including a communal lounge, quiet lounge, conservatory and dining room. The majority of bedrooms are for single occupancy and many have ensuite facilities.

The provider had arrangements in place to protect people from risks to their safety and welfare. Arrangements were also in place to store medicines safely and to administer them according to people's needs and preferences. People were supported to access healthcare services, such as GPs and community nursing teams.

Staffing levels were sufficient to support people safely and in a calm, professional manner. Recruitment processes were followed to make sure only workers who were suitable to work in a care setting were employed. Staff received appropriate training and supervision to make sure they had the skills and knowledge to support people to the required standard.

Staff were aware of the need to gain people's consent to their care and support. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The arrangements included processes and procedures to protect people from the risk of abuse.

People were supported to eat and drink enough to maintain their health and welfare. They were able to make choices about their food and drink, and meals were prepared appropriately where people had particular dietary needs.

People found staff to be kind and caring. They were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected people's individuality, privacy, dignity and independence.

Care and support were based on plans which took into account people's needs and conditions, but also their abilities and preferences. Care plans were adapted as people's needs changed, and were reviewed regularly.

People were able to take part in leisure activities which reflected their interests and provided mental and physical stimulation. Group and individual activities were available if people wished to take part.

The home had an open, friendly atmosphere in which people, visitors and staff were encouraged to make their views and opinions known.

Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided. The provider took action where these systems found improvements could be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Magnolia House

Detailed findings

Background to this inspection

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was unannounced and was carried out on 10 and 17 August 2017 by one inspector. On 10 August 2017 an expert by experience in the care of older people was also present. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with ten people who used the service and four family members. We also spoke with the provider's representative, registered manager, eight care staff, two kitchen staff, housekeeping staff, the activities coordinator and two health care professionals. We observed care, support and activities being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care plans and associated records for four people using the service. We also looked at a range of records relating to the management of the home including four staff recruitment files, records of complaints/compliments, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in July 2015 when no issues were identified.

Good

Is the service safe?

Our findings

Everyone told us they felt safe at Magnolia House. One person said "I like it here, it is homely". Family members told us they did not have any concerns regarding their relative's safety. One family member said, "Mum's safety was one of our main considerations when choosing Magnolia House, they know how to look after people with dementia and keep them safe". We saw that people appeared relaxed and happy.

Staff protected people from the risk of abuse and were clear about their safeguarding responsibilities. Staff knew how to identify, prevent and report abuse and all staff, including those not providing direct care for people, had received appropriate training in safeguarding. One staff member told us "I would not hesitate to report any concerns first to the manager and if they did not take action, which I know they would, to you (CQC) or safeguarding". Another staff member said, "If I was concerned I would go to [name of the registered manager], or higher if I needed to". The registered manager explained the action they had taken following a recent safeguarding concern. The action taken had included seeking support from relevant external professionals and ensuring the ongoing safety of people concerned.

People were supported to receive their medicines safely. All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Procedures were in place and followed to ensure that the balance of medicines was correct and that people had received medicines as prescribed and as recorded on medication administration records (MAR). Staff were aware of how and when to administer medicines to be given on an 'as required' basis for pain or to relieve anxiety or agitation. Should people be unable to explain they were experiencing pain a recognised pain assessment tool was available. Where people had been prescribed 'as required' (prn) medicines, there was a prn plan which explained when the medicine could be given. Training records showed staff were suitably trained to administer medicines and had been assessed as competent to administer medicines. Staff administered medicines competently, explaining what the medicines were for and did not hurry people. The provider had good systems for the safe management of medicines in the home.

Individual risks for people were managed safely. All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling, nutrition, moving and handling and developing pressure injuries. Risk assessments had been regularly reviewed and were individual to each person. These procedures helped ensure people were safe from avoidable harm. Where people had fallen, comprehensive assessments were completed of all known risk factors and additional measures put in place to protect them where necessary. Staff had been trained to support people to move safely and we observed equipment, such as hoists and standing aids being used in accordance with best practice guidance. Staff explained the risks related to individual people and what action they needed to take to mitigate these risks. Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents.

There were sufficient numbers of staff on duty to meet people's needs. People told us staff were available when they needed them. One person said "Someone [staff] is usually around, they keep an eye on us". A

visitor told us "There is normally enough staff, they are busy but always seem cheerful". The registered manager told us that staffing levels were based on the needs of the people using the service. They described how they used their staffing budget flexibly to provide more staff at times when these were required. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime or agency staff. Staff were not rushed and were able to respond to people's requests for assistance in a timely manner. Staff felt that the staffing levels were suitable to meet the needs of the people. Staff comments included, "There is normally enough staff, the manager will get agency staff if needed".

The provider had a safe recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. A staff member confirmed that they were unable to start work at the home until their DBS had been completed. The provider's application form requested ten years employment history as opposed to the required full employment history. The registered manager immediately amended the provider's application form to ensure they requested a full employment history and undertook to review recruitment files to ensure, where needed, this information was sought.

All areas of the home were clean and well maintained. One relative said "I have visited a number of care homes and whenever I enter I do the 'nose test' and this home smells clean". Housekeeping staff worked throughout the home, causing the least disruption possible to people. For example, at lunch time when everyone had moved out of the lounge for lunch the cleaners gave the room a thorough clean.

There were clear emergency procedures in place. Staff knew what action to take if the fire alarm sounded. Fire drills had been undertaken regularly and staff were trained in fire safety and the use of evacuation equipment. People had personal evacuation plans in place detailing the support they would need in an emergency. Staff had also undertaken first aid training and were able to correctly describe the action they would take in an emergency. Staff had 'walkie talkies' which they could use to communicate with other staff and get support promptly if required in an emergency.

Good

Is the service effective?

Our findings

People, their families and healthcare professionals told us they felt the service was effective. People said that the staff knew their needs well. One person said "The staff are very good, nothing is too much trouble". Another said "The staff know me and how I like things done, they are lovely". A third person said "The staff are very good, they know what they are doing". A healthcare professional said, "The residents are well looked after, I think it's a good home".

People told us staff knew how to care for them and told us their needs were met. People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. A health professional told us, "When I come here there is always a staff member to support me and they know what is going on with the residents".

In one care plan we identified conflicting information as to how often a person's blood sugar levels should be checked. The registered manager took immediate action to clarify with community health professionals how often the checks of blood sugar levels for people living with diabetes should be undertaken. With the guidance of the community health professionals they amended the diabetes management care plans for people living in the home. The updated care plans were viewed on the second day of the inspection and provided clear information about how each individual person should be supported.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests.

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). We checked whether the service was working within the principles of the MCA, and whether DoLs applications had been made appropriately. We found the provider was following the necessary requirements and where appropriate, DoLs applications had been made and reviewed. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence.

People told us that staff asked for their consent when they were supporting them. One person said, "They always ask my consent" and another person told us, "If I say I'm not ready yet (to get up) they come back a bit later". Daily records of care showed that where people declined care this was respected. Staff showed an

understanding of the legislation in relation to people living with dementia. Before providing care we saw staff sought consent from people using simple questions and gave them time to respond before undertaking the required care or support. For example, they asked people if they would like to move to the dining room before they supported them to do so and they would ask the person they were supporting, where they would like to sit. Where people had capacity to make certain decisions, these were recorded and signed by the person. A member of care staff said "The people we support don't always remember that they have used a stand aid and we need to give lots of reassurance and consent. But that is how we should treat people".

Everyone we spoke with was complimentary about the food. One person said, "The food is very good and we always have a choice". One relative said "The food is good, in fact [name of relative] is eating things I have never seen her eat before". People received appropriate support to eat and drink enough. Staff supporting people to eat their lunch did not rush them with their food and spoke with them gently during the whole process. People were encouraged to eat and staff provided appropriate support where needed, for example, by offering to help people cut up their food. Most people chose to eat in the dining room where they sat in small groups at tables for four to six people. Tables looked attractive and had been laid with tablecloths, serviettes, cutlery, glasses and placemats. This helped make the mealtime a pleasant and sociable experience.

People were offered varied and nutritious meals which were freshly prepared at the home prior to each meal. This included, if people wanted, a full cooked breakfast, lighter lunch and a main meal in the evening. Alternatives were offered if people did not like the menu options of the day. Drinks were available throughout the day and staff prompted people to drink often. Special diets were available for people who required them and people received portion sizes suited to their individual appetites. Catering staff were aware of people's special dietary needs and described how they would meet these. Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration. They monitored the weight of people each month or more frequently if required due to concerns about low weight or weight loss.

People were supported by staff who had completed the provider's mandatory training. All staff, including catering and housekeeping staff undertook the same basic training. New staff received induction training which included shadowing experienced staff and undertaking the Care Certificate. This sets the standards people working in adult social care need to meet before they can safely work unsupervised. Records showed staff were up to date with their training and this was refreshed regularly. One staff said "we get lots of training and the training is really good". Most staff had obtained vocational qualifications relevant to their role or were working towards these.

Staff were supported appropriately in their role. They received one-to-one sessions of supervision, observed practise and a yearly appraisal with the registered manager. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. Staff said they felt able to approach the registered manager or the provider's representative if they had any concerns or suggestions for the improvement of the service.

The environment was well maintained and appropriate for the care of older people with specific adaptations such as passenger lifts to all floors. Decoration had taken account of research to support people living with dementia or poor vision to find their way around the home. This included brightly coloured doors to bathrooms and toilets and hand rails of contrasting colours to walls. People had access to the gardens which were safe, fully enclosed and provided various seating options. The registered manager told us about additional work that was planned for the gardens to provide a safe area for any visiting dogs.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People and family members agreed that staff were caring. A visitor said "The staff are very good and look after [name of relative] very well". Another visitor told us "The staff are very caring and cannot do enough". People also told us staff were caring. Comments included "The staff are always cheerful", "The staff are very kind" and "They [staff] really look after us". We saw thank you cards which had been received by magnolia House. These all reflected that staff were kind and caring.

People were cared for with dignity and respect. We saw staff kneeling down to people's eye level to communicate with them and heard good-natured conversations between people and staff. One person who had fallen asleep looked as if they may be uncomfortable. Staff gently repositioned them and placed a cushion under the person's arm to improve their posture. We observed that staff were kind, affectionate, knew each person well and responded promptly to people who were requesting assistance and they did so in a patient and attentive way. Staff spoke with people while they were providing care and support in ways that were respectful.

Staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and we observed that people were offered choices in what they preferred to eat, where they wanted to sit and if they wanted to take part in activities. A staff member said, "I always tell people what I'm going to do and give them the choice". One person said, "I am always offered choices" and a second person told us, "They [care staff] listen to me". Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wished to remain in their rooms, this was respected. People were provided with choice about their food. One person was struggling to make their choice, the care staff member asked if they would like to see the sandwiches and brought a plate of covered sandwiches and explained what was in them. This helped the person make their choice. Two people asked for soup but when it was presented to them, they decided that they did not want the soup. The care staff member did not make an issue of it and offered a choice of sandwiches instead. The people agreed to a selection of sandwiches and ate them.

We saw that people's privacy and dignity was respected. This was with the exception of one occasion when we observed staff using equipment to move a person between chairs. This was not undertaken in a way that ensured the person's dignity. We told the registered manager about what we had seen and they took action to remind staff of the need to protect people's dignity during transfers. Staff told us they ensured people had privacy when receiving care. For example, keeping doors and curtains closed when providing personal care, and keeping people covered as far as possible during personal care. Magnolia House had three rooms which could be used to accommodate two people. The registered manager was clear that this would only occur if people specifically requested a shared room such as if a married or long term couple were admitted to the home.

People were supported to be as independent as possible and staff understood people's abilities. One person said "I am supported to do as much for myself as I can". Care plans gave clear information about

what people were able to do for themselves and when support was required. Comments in care plans included, "[person's name] can wash their upper body but requires assistance with lower body" and "[person's name] is able to clean own teeth". People confirmed that the staff only helped when they need it. We observed staff encouraging people to be as independent as possible. One member of care staff monitored a person as they used their walking frame to walk to the toilet. They encouraged the person and reassured them that they were doing well.

People were supported to maintain friendships and important relationships; people's care plans identified people who are important to them. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships.

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Good

Is the service responsive?

Our findings

People were provided with personalised care. Initial assessments of people's needs were completed using information from a range of sources, including the person, their family and other health or care professionals. Care plans contained information about people's life history, preferences, medical conditions and behaviours. They each contained a detailed description of the individual care people required covering needs such as washing, dressing, bathing, continence and nutrition. These detailed what people could do for themselves and how they needed to be helped. This helped ensure people received consistent support and maintained skills and independence levels. Where able people had signed care plans and risk assessments which demonstrated that they had been involved in the planning of their care. Where people lacked capacity relatives had been involved in care planning. Reviews of care were conducted regularly by senior staff although these did not always involve the person or their families. As people's needs changed, care plans were developed to ensure they remained up to date and reflected people's current needs.

Staff used the information contained in people's care plans to ensure that care provided met the individual needs of the people. A health professional told us, "The staff seem to know the residents well". They continued to tell us how the service had worked with them and the hospital to ensure a person could return to the home for their final days. They commented that the person was receiving all the care they required and was clearly happy to be back at Magnolia House which had been their request. People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Care was individual and centred on each person and staff had a good awareness of people's needs. Care staff were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required with their personal care and when mobilising. This corresponded to information within the person's care plan.

All staff, including those not directly employed to provide care responded to people's needs. We observed one person enter the lounge during lunch. We had previously noted that they found it difficult to stay in one place for long. One of the housekeepers followed them in, was wearing a blue food preparation apron and gloves and carrying a plate of sandwiches. The housekeeper asked the person where they would like to sit and once sat they placed the sandwiches in front of the person so they could eat them. The housekeeper asked the person what they would like to drink and brought the drink of choice. Other housekeepers were cleaning the lounge whilst other people were in the dining room. They worked around the person, allowing them time and space to eat their lunch.

Opportunities for mental and physical stimulation were provided by activities staff six days a week. People told us there were always activities available. One person said "There is always activities I can join in with." Throughout the day various activities were provided. These were amended to meet the needs of people participating. For example, we observed a game of bingo. When the first game had been completed with those who could be actively involved, another version of the game, for those who were not able to fully participate, occurred. This meant everyone got something out of the activity. A more physical activity also occurred involving various balls and people being encouraged to throw and catch these. The activities staff member explained that some people who find fine motor skills difficult engaged when large balls were

introduced. We observed people who had not previously engaged with any interaction, come alive and fully participate in catching, kicking and throwing a beach ball. People who preferred or needed to spend more time in their bedrooms were also provided with some individual activities. Outings and individual trips out were also organised and we saw these occurring on the second day of the inspection.

People were provided with information about how to complain make comments about the service through information in the 'residents' handbook' seen in each bedroom. Relatives and people told us they had not had reason to complain, but knew how to if necessary. They said they would not hesitate to speak to the staff or the managers who they said they saw regularly and who were very approachable. One visitor told us they knew how to raise a concern and that "Any time I have raised an issue or asked for something for [name of relative] it was dealt with, without fuss and always with a can-do attitude". The complaints records showed that when complaints were made these were investigated comprehensively. The person or relative who had raised the complaint received a full written response including, where necessary, an apology and information as to what would be done to resolve the issue.

Good

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. Family members and healthcare professionals also said they would recommend the home to their families and friends. One person said "The manager is always available and she is very approachable". Another said "The manager is lovely". One of the relatives told us "The management is very good, approachable and willing to listen. The manager sorts things out without fuss".

There was a registered manager in place. 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.

There was a clear management structure, which consisted of a registered manager, team leaders, senior care staff, care staff and ancillary staff. Staff understood the role each played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. Staff members comments included, "[name of registered manager] is very approachable and listens to us" and "The home is well organised". Regular staff meetings were held providing an opportunity for the registered manager to engage with staff and reinforce the provider's values and vision.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area and on the provider's website.

People were given opportunities to express their views about the service. They said they were asked for their opinion and all felt they were listened to. One person said "I am asked for my opinion all the time and I am listened to". Another person said "I give my opinion whether I am asked or not, but they always listen and respond appropriately". The registered manager met individually with people to seek their views about the service on a regular basis. People and relatives were also able to express their views anonymously via an external organisation with freepost envelopes and comment cards available in the entrance hall. The registered manager said they made a point of talking with people and visitors and felt this meant people could raise any issues in an informal way which could be quickly resolved.

Observations and feedback from staff showed the home had a positive and open culture. The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member said, "I really enjoy working here". The provider had suitable arrangements in place to

support the registered manager, for example regular meetings, which also formed part of their quality assurance process. The registered manager told us that they felt well supported by the provider and received regular one to one meetings and supervision.

On the first day of the inspection we identified minor areas which could improve the service. By the second day of the inspection the registered manager had taken action to address these. Over the past few years various parts of the home had been upgraded and we were told of further plans to improve the environment for the benefit of the people living there. The ethos of the provider and staff was one of continuous improvement for the benefit of people living at Magnolia House.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The provider employed a health and safety lead who carried out quality assurance process and provided documentary feedback of their findings to the provider and registered manager. The registered manager and provider carried out regular audits which included medicine management, infection control, the environment and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures and fire safety. Where issues or concerns were identified action was taken.

There was an extensive range of policies and procedures which had been adapted to the home and service provided. Any new policies were reviewed internally by the registered manager before being put in place to ensure they reflected the way the home was working. This ensured that staff had access to appropriate and up to date information about how the service should be run. A folder containing policies and procedures was available to all staff at all times in the care office.