Enter and View Report:
Magdalen House Care Home

6th November 2017
Name and Address of Service visited:
Magdalen House Nursing Home
Magdalen Road
Hadleigh, Suffolk
IP7 5AD

Name of Provider:
Alysia Caring Luxury Care Homes

We visited this service on:
An announced visit on 6th November 2017
**Acknowledgements:**

Healthwatch Suffolk (HWS) would like to thank the service provider, residents, visitors and staff for their contribution to the Enter and View programme.

**Disclaimer:**

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all residents and staff, it is an account of what was observed and contributed at the time.

**What is Enter & View?**

Part of the local Healthwatch programme is to carry out Enter and View (E&V) visits. These may be announced or unannounced.

Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement.

The Health and Social Care Act allows local Healthwatch ‘Authorised Representatives’ to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.

Enter and View visits can happen if people tell us there is a problem with a service but they can also occur when services have a good reputation – Healthwatch Suffolk wants to learn about and share examples of good practice from the perspective of people who experience the service first hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies.

If at any time an Authorised Representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit.

In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the CQC where they are protected by legislation if they raise a concern.
EXECUTIVE SUMMARY...

“Action needs to be taken to improve the well-being and spiritual care offered to residents.”

Magdalen House provides accommodation and care for up to 53 people. Care is provided on three separate floors: the ground floor is a residential unit, a designated dementia care unit is on the first floor and the second floor is for people who are more independent.

Magdalen House had a Care Quality Commission (CQC) inspection on 1st March 2017 (published on 21st June 2017) when it was rated as Good.

However, since the CQC inspection in March 2017 Healthwatch Suffolk (HWS) had received several negative reports from relatives of residents living at Magdalen House. These indicated that there may be staffing shortages as well as claims that new residents were not properly assessed and were not provided with a care plan at the beginning of their stay in the home.

Provider response:
“This is quite concerning to us as none of these issues were raised with us. We had our unannounced CQC visit, as your report states, in March, and we were found to have sufficient staff on duty and we have since then added extra staff at the home. We were not asked about staffing otherwise we would have shown the visitors our rota.”

Assessment of residents were not raised with us as an issue as we would have explained and shown them our pre-admission assessments. It appears that the report writer has picked up on a point raised in our CQC report and added in this report without any evidence.

Healthwatch Suffolk response:
The feedback referred to is on the Healthwatch Suffolk feedback centre which is accessible to anyone on www.healthwatchsuffolk.co.uk/services. Providers have the right to reply.

The design of the Home presents challenges to the provider which are difficult to overcome.

The design is simple and functional and may have appeared to be efficient. However, having three floors without space for a communal lounge on each floor undermines the objective of enhancing the independence of the more able residents.

Provider response:
This part of your report is inaccurate as we have lounges on both our floor and have a Bistro & Cinema room on the top floor. As you may be aware, the home is relatively new and obtained full planning permission for the design from the relevant authorities.

Conversations with residents provided a good insight into their experience of living at Magdalen House. The E&V team came away with a feeling of sadness that so many residents appear to be ‘existing’ in the home on a day to day basis without the opportunity to take part in stimulating activities, to go outside or engage with the community. Action needs to be taken to improve the well-being and spiritual care offered to these residents.

Provider response:
We design our activities according to their choice and they join in, they have one to ones, they go out - accompanied and on their own, we have outside entertainers and their families visit them, some daily and some weekly. We have relatives meeting in which we discuss activities at the home and they contribute ideas, we haven’t had any concerns raised for a long time. May I respectfully remind you that residents cannot be compelled to join activities, but they are encouraged to do so.

We would like this part to be amended to reflect what actually happens and not what the team feels.

Healthwatch Suffolk response:
Enter & View reports are based on observations
made and comments received, during the visit.

The carers were highly regarded by the residents and demonstrated a kindly, caring and sensitive manner and responded well to residents’ practical needs and to some emotional needs, particularly with residents with dementia. The team felt that the carers had been provided with the necessary initial and refresher training on safeguarding and dementia awareness.

The home endeavoured to carry out pre-admission assessments of resident’s needs, and this formed the basis of an initial care plan, which often included end of life wishes. However, the team did not feel that residents are sufficiently involved in their care planning in relation to their personal needs or interests in relation to meals or activities.

Provider response:

We have review forms which have been completed by families and residents who have capacity to state how often they would like to join in their reviews, and we have “This is me” completed for our residents and this assist in developing their care plan in relation to their needs, activities and meals.

Again, we feel this part should be amended or removed from this report as it factually incorrect.

RECOMMENDATIONS

These recommendations include actions which do not need to be time consuming or costly and some could save money and reduce waste; others will improve the quality of life of residents.

Recommendation 1:

Action needs to be taken to improve the wellbeing and spiritual care offered to residents. The team came away from the visit feeling extremely sad that so many residents appeared to be ‘existing’ in the home on a day to day basis without the opportunity to go outside, engage with the community, or take part in any stimulating activity. The team provided the Proprietor with a copy of the Healthwatch Suffolk report on “Spiritual Care” (and wellbeing) and recommend that due attention is given to the examples of good practice in that report. Members of staff should be given opportunities to visit other homes to gain an insight into how meaningful activities, good spiritual care can be delivered, and individual needs met. Truly person centred, or individual care requires more than providing a clean, modern and supportive environment which meets KPIs set by a proprietor. The term ‘luxury care’ is used by the proprietor to describe the home however luxury care needs to be more than providing an environment where physical care can be provided.

Provider response:

We have a visiting Lay Elder from the local church, who visits every two weeks to provide holy communion to our residents. We have the Vicar who visits the home for big occasions, he was last here for Christmas and will be next here for Easter. We take our residents to the local church if they wish to go and so do their families. Again, our residents are able to voice their choices and we respect them as spirituality cannot be forced on residents. Their care plan identifies who likes to go to church and who doesn’t practice religion.

As you are aware, CQC regulations require us to maintain financial viability of the home.

We would like this part to be amended to reflect what actually happens and not opinions of the visitors that are factually incorrect.

Healthwatch Suffolk response:

Spiritual Care is not simply about religious belief or observation of a faith it is about enabling individuals to participate in interests and activities that they find stimulating and are of interest to them.

Healthwatch Suffolk recommends that the management team refer to a number of service journals and guidelines around spirituality and person-centred care including the CQC handbook which recognises that for care to be responsive providers must give consideration to every individuals religion and beliefs and be
supported to follow their interests and take part in social activities which are meaningful to them. ‘How are residents listened to and their rights and diverse circumstances respected’. CQC (2015) Provider Handbook

The Health and Social Care Act 2008 regulation 8 states that:

‘The intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences. Providers must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves’.

**Recommendation 2:**
Additional training by an external agency should be provided for all staff in the promotion of independence for all residents but especially for the more able residents.

**Provider response:**
We do have external bodies providing training in the home in the home and have recently had dignity in care training and Gert suit training form from the local authority. This remark therefore is factually incorrect and should be amended.

**Recommendation 3:**
Residents with dementia should be given the opportunity to develop their own reminiscence box of photos, souvenirs and artefacts to stimulate conversation and memory. Similar boxes should be created and topped up periodically and be available in the lounges for all residents and visitors to use.

**Provider response:**
Some of our residents have their own reminiscence items or boxes and they are kept in their room and they are used as part of activity and we have communal boxes which are also kept in the activity cupboard and used. The E&V team need to understand that the use of these boxes/items have to be supervised as some of our residents on the Dementia floor tend to eat some of the items in them that shouldn’t be consumed.

**Recommendation 4:**
As the home is in the process of refurbishment the E&V team recommend that the work includes some planning to reduce the bland and unstimulating decor. This could include more personalised and relevant displays depicting residents enjoying activities inside and outside the Home. The team also suggest that the Proprietor considers the best ways to overcome some of the design deficiencies of the building and seeks advice from appropriate professionals to create more intimate and informal spaces where residents can enjoy a wider range of stimulating experiences.

**Provider response:**
We have now completed our redecorations and refurbishment programme on the Dementia floor and we have received positive feedback from residents, relatives and staff.

We do consult with our residents and relatives, who are at the heart of our home and at their suggestion re-designed the upstairs lounge in a bistro and Cinema room for them to use.

We are currently working on the garden, to be ready for the summer.

**Recommendation 5:**
Hand hygiene for residents and carers, especially at meal times should be improved and hand hygiene dispenser points for staff or visitors should be provided at key points in the building to reduce the risk of infection.

**Provider response:**
Hand hygiene is taken in consideration when dealing with our residents at meal times and staff have been reminded to offer residents wipes
to clean their hands. Staff have access to hand hygiene facilities and we encourage our staff to wash their hands with soap and water. We have one dispenser in the reception which can be used on entrance and departure and we would like to point out that we are a residential home and not a hospital ward, to warrant dispensers everywhere. We do however hold hand gel on each floor which are used by relatives when we have an outbreak.

**Recommendation 6:**
Residents and, where relevant, their families should be given more opportunities to exercise choice and control, for example in relation to activities or food for example by the use of menu cards and greater consultation on the menus themselves.

**Provider response:**
We do give residents and their families a choice in relation to food and activities, by discussing menus and activities in relatives and residents meeting. We have a three-months rolling menu, and this is changed with their input. We do the same with activities and we have a board displaying the menu and activities happening in the home. Residents are given choices at meal times and menu is available for them to choose from.

**Recommendation 7:**
Residents and relative’s meetings should be held on a regular basis and should be advertised in an effective and accessible manner.

**Provider response:**
We do hold 3 monthly relatives and residents meeting, and this is advertised on our activities board, reception desk and in our newsletter. We also send out invitation to relatives where needed. We are currently working with relatives try and send emails to those who wish for us to do so.

**Recommendation 8:**
There should be better engagement and integration with the community for example by the recruitment of ‘friends’ or volunteers who could support the Activities Co-ordinator and other staff to help the residents to become more integrated with the community, for example by visiting some of the nearby shops in the High Street. Volunteers may also assist with the promotion of activities in the Home. There may be groups in the community who would also be able to help or which some of the more able residents could join.

**Provider response:**
We believe we are well integrated with the community, we are visited by Hadleigh Parkside playgroup, the Brownies group, the HDDA, Beaumont Primary School and; people from St Mary’s church. Our residents do go and visit the local shops and we actively encourage volunteers to join our team.

**Recommendation 9:**
The adjacent Day Centre, which is separate to the main service offers potential additional space of a large room with pleasant furnishings. It is accessible from the ground floor of Magdalen House. The day centre attendees leave at about 1500 hours at which time outside groups such as a local history group, craft club, singing or choir groups could be encouraged to use the room. These groups might be of interest to Magdalen House residents, giving them more choice of activities.

**Provider response:**
We do use the day centre but have taken this on board and have started using the day centre more regularly at the weekend.

**Recommendation 10:**
The requirements of the NHS Accessible Information Standard should be considered in relation to all communications for and about residents. An information leaflet was left with the Home Proprietor.

**Recommendation 11:**
The culture of the home is one dependent on the selection, appointment and training of sufficient staff, reporting KPIs, internal monitoring of performance and close supervision of managers and senior staff. The relationships between carers and residents seem to be good.
1. **Visit Conducted by:**

Lead Authorised Representative:

- David Evans

Authorised Representatives (ARs)

- Helen Hollinworth
- Joanne King
- Stella Morris
- Steve Pitt (Healthwatch Suffolk Director) as an observer as part of his induction into his new role with Healthwatch Suffolk as a recently appointed Director.

2. **Purpose of the visit:**

2.1 Given that there were potential concerns about staffing it was decided to only give ten days’ notice of the visit in the hope that there had been insufficient warning for additional staff to be provided on the day of the E&V visit.

2.2 The main purposes of the visit were to provide an understanding of what a CQC rating of ‘Good’ looked like and, in light of the complaints to Healthwatch Suffolk, to consider whether or not, in our view, this rating was still justified. The team were interested to find out how standards within the home are established and maintained and how these are communicated to and experienced by residents, relatives and staff. The E&V letter to the home announcing the visit described particular aspects that the team wished to consider:

   I. The lived experience of the residents and how they are kept safe
   II. How residents are involved in planning their care, daily activities and meal choices
   III. How do staff engage with residents and respect their dignity and privacy (especially for those with cognitive impairments)
   IV. Pre-admission assessment procedure

2.3 For each of these aspects and the previous CQC findings the E & V team devised a series of basic questions which formed a check-list for each of the ARs to use to describe and analyse their observations at Magdalen House.

**Provider response:**

The team seem very reluctant to tell us who they were and what experience they had. We believe they came in to look for issues as stated by themselves “The main purposes of the visit were to provide an understanding of what a CQC rating of ‘Good’ looked like and, in light of the complaints to Healthwatch Suffolk, to consider whether or not, in our view, this rating was still justified.”

We went through a thorough unannounced CQC inspection, by experienced inspectors, who found the home to be “Good” and we believe we worked hard to achieve the rating.

We also find it unprofessional that the E&V team would suggest that, had we been given more time we would have put extra staff on as stated in the report “Given that there were potential concerns about staffing it was decided to only give ten days’ notice of the visit in the hope that there had been insufficient warning for additional staff to be provided on the day of the E&V visit.”

The feedback we received from staff were that the team was intimidating and they
didn’t enjoy the visit.

**Healthwatch Suffolk response:**
Who the team were and purpose of the visit: the proprietor and manager had both received an electronic and mail letter prior to the visit outlining the visit, its purpose and names of the five authorised representatives.

Enter & View visits and subsequent reports are completed by Healthwatch Suffolk volunteers who are recruited specifically for the role of Enter & View ‘authorised representatives’. Most of the volunteers are from a health or social care background. The volunteers undergo specific training for the role of authorised representative.

Please see Appendix A which contains short biographies of the five experienced volunteers who were involved in this visit all of whom have a health or social care background.

In terms of additional staff on duty to cover Enter & View visits, it has been the experience of Healthwatch Suffolk that some providers do rota on more staff to cover the duration an Enter & View visit, thus giving a false impression of staffing levels and the ratio of staff to resident.

**Methodology:**

3.1 Observation of the service: Two members also visited the three floors of the Home to assess the facilities, environment and to talk with the residents and staff. Individual members joined residents to share lunch with them.

**Provider response:**
We found the number of visitors who came in was excessive, we are a 53-bedded home and having 5 people in, disrupted the daily life of our residents. We believe this should have been discussed with us prior to the visit as we were led to believe there would be only two visitors.

**Healthwatch Suffolk response:**
The provider and proprietor were notified in advance of the visit by letter, both electronically and by post. The five Enter & View authorised representatives were named in the letter.

3.2 Discussion with management and staff: The E & V team divided into two groups for the initial part of the visit with two members speaking to the Deputy Manager, in depth.

A “focus group” with relatives was planned for the end of the visit however, no relatives came to the session and the team only spoke to two relatives who happened to be visiting whilst the team were on site. This was perhaps a consequence of the limited notice given of the visit.

**Provider response:**
Posters were put out as requested by E&V team and relatives didn’t attend as they had nothing to contribute.

3.3 For each aspects of the visit the E & V team devised a series of basic questions which formed a check-list for each of the ARs to use to describe and analyse their observations.

A feedback session was provided by the Lead AR and one other AR at the end of the visit to the manager.

**Provider response:**
The feedback session given to us was very disjointed and we found it quite unprofessional, as wording, such as “foreign staff” were used when asking about staff we had from mainland Europe. It was suggested that we had too many when in fact we only had two staff members, one on night and one on day duty. Both are really good staff members.
and liked by the residents.

**Healthwatch Suffolk response:**
To clarify, by mentioning foreign care staff the team were referring to staff whose first language is not English, an issue raised in the CQC report dated 8 August 2016 page 16 where the report stated:

“From feedback received before and at the time of our (CQC) inspection we were not confident that there were always sufficient staff on duty for the needs of people using the service or that all staff were sufficiently competent and skilled. One person told us that some staff on nights did not speak much English and that this could be difficult”.

*CQC Report 8 August 2016, page 6 “Is the service safe”.*

The E&V team subsequently identified good practice on page 35 para 6.7 where the language skills of one of the bi-lingual Portuguese carers was recognised as being important to a Portuguese resident.

3.6 This Healthwatch Suffolk visit focused on three areas:

i. Management and staffing, including training
ii. Assessment of the environment and facilities
iii. Experience of residents, including satisfaction with care, meals and well-being and spiritual care.

4. **Introduction:**

4.1 Magdalen House is a 53 bed-roomed modern home purpose built in 2012. It is on a very central site in Hadleigh, one street back from the High Street, and almost adjacent to a large public car park. The E&V team were told that it was built by developers and a family couple ran it themselves for the first year or so until the home was purchased by its present owners, the Alysia Care group. The original owners were described as a very caring couple but not as experienced in running (or designing?) a large residential home.

4.2 The design of the home, in the view of the E&V team, is functional but lacks any “nooks or crannies” where residents can find a quiet corner to enjoy quiet conversation with each other or with their relatives or friends. Long, relatively narrow, corridors lead from the lounges situated on the first two floors to the residents’ bedrooms. The accommodation looked well cared for and there was evidence of recent or on-going re-decoration. Many walls were decorated in rather plain and dull colours and although there were some colourful murals large areas were blank. Where there were pictures on display they tended to be the sort you might find in “IKEA” or a hotel, and were not personalised or particularly relevant to the residents’ activities or the communities they had come from.

4.3 On the first-floor dementia care is provided. There was a smell of urine at the time when the team were shown around. The corridors are plain but the hand rails are brightly coloured and the resident’s doors are of varying colours to assist with some independent movement around the unit. Most doors had a current picture of the resident, although they did not seem to be flattering pictures that the residents would have chosen for themselves? It was not clear for whose benefit these were displayed; was it to remind the carers who was behind the door? The pictures did not relate to the family of the resident or their past occupation, as has been seen elsewhere, which could have provided a useful trigger for a conversation between the resident and their carer or visitor.

4.4 The second floor is quite separate
from the other areas of the home. It is described as suitable for people who are more independent and in the brochure the rooms are described as “superior” and have the advantage of en-suite facilities (as do all rooms) plus a fridge and a microwave.

5. What we found - impressions and findings of the service (including NHS Accessible Information Standard):

Lounge areas

5.1 There is a separate lounge area on floors one and two. There is no lounge on the second floor as the only communal room is known as the “Bistro and cinema” and has refreshment facilities for visitors and relatives. No care staff are based on this floor and once residents have been assisted to get up in the morning staff only come up to the floor to respond to the call bell. Residents on this floor either choose to remain alone in their room or join with other residents in the ground floor lounge.

5.2 There was limited variation in the height of the chairs provided in the lounges but overall the furniture appeared durable with some chairs having pressure relieving cushions.

5.3 The chairs in the lounges were not arranged in small groups which are more conducive to conversation but were mainly spread around the walls and lacked homely touches with little soft furnishing. Soft drinks and fruit were available on a tray in the resident’s lounge.

Provider response: The lounge is set in this manner as the residents like to see who is sitting by them and we disagree that soft furnishing are lacking as there are several cushions and blankets on the floor for use.

5.4 On the first floor there was a painting activity session taking place for a small group of residents engaged in activities using “Creative Mojo” (a franchise delivering pre-made cut art shapes / activities for people with cognitive impairments) in the lounge which had hard floor therefore the area seemed noisy.

5.5 On the ground floor lounge there was a buzz of conversation amongst some groups of residents, but most residents were sitting passively or sleeping in their chairs and there was no real homely atmosphere.

Provider response: Again, we would disagree with the representation by the team as residents on the ground floor are able residents, who enjoy their own activities such as reading, knitting and talking to each other. Some residents may be tired and have dozed off.

Dining rooms

There are separate dining rooms on the ground and first floors. The dining rooms are set out with small tables for four people. Meals are served from a trolley. There was a chalk menu board on the wall displaying the meal options. This was hand-written and was difficult to read, even for the Healthwatch Suffolk visitors.

Provider response: We have taken this on board and have now have typed menus displayed in the dining room.

Bathrooms

All rooms have en-suite facilities, but the home also has a well-equipped bathroom on the ground and first floor. These appeared to be unused, other than for storage.

Hairdressing Salon

A self-contained hairdressing salon is
provided on the first floor which is run by one of the carers who is a trained hairdresser.

**Garden**

Magdalen House was built on the site of a bowls club and has limited outdoor space. It has what is described in the brochure as ‘landscaped gardens’ which are more of an enclosed courtyard and patio with shrubs, a raised bed and some bird feeders. The garden is maintained by an in-house handyman, the E&V team were told that residents helped to plant the raised bed but there was no evidence or photographs of residents using the garden or being involved in outside activities.

**Provider response:**
The visit was in November and residents do not like to go out in the winter to plant. This will now start in spring and summer when the weather is more conducive for these activities.

We will be making use of the garden area for producing fruit/vegetables and/or other plants that may be of use internally (i.e. flowers for a vase).

We will also plant a herb garden on the raised bed in the garden and will encourage our residents tend to them and the herbs would be used in the kitchen.

We will also encourage the residents to help with the flowers for the hanging baskets in the summer.

**Findings**

a) Management: methods and systems

**Introduction**

Questions were asked to understand the relationship between what CQC had called the Proprietor and the Home Manager, especially as the Home Manager had left just before the E&V visit. CQC had also stated that there were “systems in place” to monitor performance, the team wanted to find out how the provider monitored activity in the home to identify trends and incidents which might drive improvements.

The E&V team also wanted to understand what ‘good provision looks like’. The team asked questions about the culture of the home and how it is communicated to staff throughout, and what living at Magdalen House is like for residents.

The team asked a specific set of questions about the NHS Accessible Information Standard.

**Findings: Management - methods and systems**

In the five years since the home has been open there have been four managers, including the original owners. The team were told that the last Manager had left recently, and suddenly, due to a combination of back pain and travel to work time, giving only given 6 weeks’ notice (rather than three months). The E&V team were also told that a previous manager (last but one) was “managed out” of the organisation because of poor performance.

**Provider response:**
This statement is not factually correct as the last manager had not suddenly left but had given 3 months’ notice and the previous manager was not “managed out” for poor performance.

**Healthwatch Suffolk response:**
This information was shared with the Enter & View team during their initial meeting with management.

The report is based on observations and comments received at the time of the visit.

Currently the manager vacancy is being covered by a Deputy Manager and she shares responsibility with Operations
Director and representative of the proprietor (Alysia Care). The group has two homes, the other being a nursing home in Peterborough. The Operations Director is usually at Magdalen House for two or three days per week. It seemed that there had been a smooth transition to the new interim arrangements.

5.15 The Operations Director said her approach to managing the home was to "train and trust" the Manager. She said she had an "open style of management based on building good relationships with staff and relatives". The Operations Director had been previously employed by BUPA in a regional role and has adapted the performance monitoring systems that they used. The management system relies on a structured framework of Key Performance Indicators (KPIs) which are set by the Operations Director for the appointed management staff. The KPIs include a requirement to produce weekly and monthly management service provision reports including complaints, staffing and staff retention, occupancy levels, safeguarding and falls amongst other matters.

5.16 The reports are monitored by the Operations Director for any common themes, trends or exceptions so that any issues of performance can be identified. This might lead to an investigation of management or care practices and could lead to a discussion about an individual carer's performance. Any concerns or other feedback is either discussed in the monthly meetings between the Operations Director and the Home Manager (currently with the Deputy) or if urgent by telephone. Senior care staff usually meet with the manager fortnightly and a meeting with carers is held on a monthly basis. There is a cascading system of supervision to individual carers.

5.17 The company (Alysia Care) uses external agencies to support its strategic framework; Quality Compliance Systems (QCS) and Crown Links Academy (a London based training company) (CLA). QCS provides the basic policies used and is contracted to keep these current and up to date to ensure that the home is compliant with the law and CQC procedures and requirements. These policies are reviewed every year. CLA provides the training material and accreditation for staff. Some of the training provided is designed to be conducted on-line and some is delivered by the Operations Director.

5.18 The culture of the home is established by ensuring that when staff are appointed they receive mandatory initial training, which includes safeguarding and dementia awareness. Staff are required to attend, are paid to do so and are disciplined if they fail to attend. The E&V team were told that a system of regular individual supervision for all staff maintains and reinforces the desired culture of the home. The needs of individual residents are monitored through monthly multi-disciplinary team meetings between the Senior Management team and external agencies.

5.19 The company has now established a stable core of staff and the Operations Director was proud of the fact that no agency staff have been employed for over one year and said because they had over-staffed by 10% they had been able to cover staff vacancies, sickness or absence with their own staffing compliment.

5.20 The interview with the Operations Director and the Deputy Manager concluded with a discussion about the NHS Accessible Information Standard (AIS). Neither of them had heard about the Standard but when it was explained to them they said that they felt that they complied with its requirements. The E&V team did not see sufficient evidence of this.
On the one hand the team were told of the good practice of the Manager or Deputy holding a pre-admission conversation at the person’s home. The aim being to complete an assessment to understand each new resident’s needs before they came to live at Magdalen House. This initial conversation, which the E&V team were assured was handled sensitively, aimed to include discussion about end of life wishes. This may include any “Do Not Attempt Resuscitation” (DNAR) instructions which are held in a “Yellow Folder” which is kept in the resident’s care plan folder used by all carers. This was a good example of how personalised care can be provided as required by the AIS.

On the other hand the information for residents, for example about the menu and meals was not provided in a way which was accessible or easy to read. Similarly, the Magdalen House Newsletter could have been more specifically addressed to residents. The font used was mostly small. The newsletter was not personalised and was introduced with the term “Dear Reader”. The newsletter seems to be aimed at both residents (it had information about birthdays and activities) and other readers for example it included phrases like “our residents enjoyed getting messy and creative” which was clearly aimed as a wider readership.

**Provider response:**
The newsletter is aimed at residents, relatives, visitors and staff.

5.21 The team did not see any information that was given to residents about the home before they moved in other than a standard brochure which was sparsely contained any real information and could be thought to be misleading both because stock photos are used to show the meals provided (the meals that the team saw being served to the residents and to the E&V team were very different) and also because of the use of the term ‘luxury residential care’ which the E&V team considered to be misleading.

**Provider response:**
Residents are given a main brochure and home specific leaflets are added to the pack. Once they come in, they have an information pack given to them which has a lot more information in it.

5.22 **Staffing Ratio and Call Bells**
The E&V were told that there is a standard ratio of one staff member to five residents, plus supervisory staff; this equated to about four carers per floor (excluding the 3rd floor which was only visited for specific tasks (getting up, washing etc) during the day. The team were told by a member of staff that there were occasions when only three members of staff were on duty which made it more difficult. At night there are normally fewer staff, but they have the support of a Senior Carer and a Manager is on-call.

Staff told us that they had sufficient flexibility to enable them to go out into the town with residents or to take them to hospital appointments. However, comments made to Healthwatch Suffolk prior to the E&V visit indicated that this was not done consistently. Healthwatch Suffolk had been told that a resident suffering from dementia had gone unaccompanied to a hospital appointment. One carer told the enter and view team “we are well staffed today” had the possible implication that this was not always the case. Another possible indication of staffing pressures was that many residents’ beds were observed to be still unmade by midday.

**Provider response:**
Staffing in the home has been increased since the last CQC inspection and we did explain that we staff the home according to dependency and we use a tool
Residents being taken to hospital do so in an ambulance with two paramedics, so are not unaccompanied and this would be case if the visit was unplanned and their family was meeting them at the hospital. Planned appointment is always accompanied either by families or staff.

Beds are made by the housekeeping staff at home and not the care staff and would not be an indication of staffing pressures. There could be many reasons why the beds were not made on that day till midday.

CQC had commented on the poor response times to call bells and Healthwatch Suffolk team members were similarly concerned at what appeared to be the almost constant ringing of call bells and consider that the delay in responding to them implied that there were insufficient staff to meet residents’ needs. It did not seem likely that should a resident need to be transported to hospital that there would be the capacity to enable a staff member to accompany them.

Provider response: This statement is inaccurate as the bells ring as quite a few of our residents use their call bell, and this doesn’t mean that there is delay in responding to them. We monitor our call bell and do ad-hoc checks and we have found that they are answered within 2 minutes.

As explained above, if a resident need to go to hospital as an emergency, then their family tend to go with them and if we need staff then we ring and ask staff to come in to cover the escort. If the visit is planned, then either staff or family are pre-booked.

Part of the reason for the frequent ringing of the call bells was that there are no staff based on the second floor which had been designed for more independent residents. Staff on the ground floor are required to attend to the needs of second floor residents, on the day of the E&V visit one resident on the top floor was bedbound, with staff mainly visiting when the resident used the call bell, or if their incontinence pad needed to be changed (which was only programmed to be changed every 4 hours). Another resident, with some impaired mobility, who normally stayed in his room and a third person was also in their room on the day of the E&V visit were also using their call bells.

It was unclear how often the residents on the second floor were checked on for personal needs etc during the day but given the length of time call bells went unanswered during the whole of the E&V visit, it would appear that residents calls for assistance are not responded to in a timely way. The Healthwatch Suffolk team had concerns that as residents are remote from staff support, residents could be at risk? One carer commented that it wasn’t possible to readily distinguish the source of a call bell from its sound (i.e. which floor) and the team suspected that this might be a relatively easy change to effect.

This was discussed with the Operations Director who responded that call bells are responded to as quickly as staffing allows but she made it clear that staffing is not 1:1 and staff must prioritise their response to resident need and in these circumstances, residents may need to wait for a response.

Provider response: Residents are checked hourly or as needed and again we would disagree that the calls are not answered in a timely manner. We do not have any concerns raised with us previous to and following the visit by Healthwatch Suffolk by relatives or residents.
**Staffing and Training**

5.27 Staff are well regarded by the residents and also by the relative spoken to by the E&V team. The residents described the staff as kind, caring and thoughtful and this was demonstrated by the many staff who the team heard calling residents by names of endearment such as “My Love”, “My Lovely” in a kindly manner however it is recognised that this may not be to everyone’s taste or seen as appropriate. No one observed appeared to object. The team did also hear carers talking to residents in more formal ways, usually by using their first name.

5.28 Staffing seemed stable without much turnover and staff had worked at the home for varied periods from a few months to a few years. One carer commented “I love it here” and when asked why she responded with “How many jobs can you go home from feeling you have made a difference?” Another care staff member also said she liked to think she made a difference in peoples’ lives but when asked to say what difference, she talked generally about ‘enabling people to have choice and dignity’ what the team hoped to hear but as she gave no examples this came across as a direct quote from a training session. However, the team did learn of an example of good practice whereby a bi-lingual Portuguese carer assisted a Portuguese resident with dementia who does not understand English. If this carer is not on duty other staff try hard to support the resident for example helping the resident to make choices at meal times by showing a choice of plated food.

5.29 Staff are required to participate in a mandatory training programme when they join. This includes dementia training using an external training module provided by the ‘Learning Curve’ agency. As mentioned above the company also uses the Crown Links Academy (CLA) to support its training programmes. CLA provides the training material and accreditation for staff. Some of the training provided is designed to be conducted on-line and some is delivered face to face by the Operations Director who delivers most of the training on safeguarding and dementia awareness. Manual handling training is provided by the Senior Carer. Staff also receive training in infection control and first aid training which includes the need to record and report incidents and when to call an ambulance. Some staff are receiving NVQ training to levels 2 & 3.

**Provider response:**
The Senior carer is a Manual Handling trainer and updates her training yearly.

5.30 Staff have refresher training on an annual basis which includes infection control and a three to four hour training session on dementia provided by Operations Director. The company seems to accord training a high priority in line with the Operations Manager stated policy of “train and trust”. A training matrix and an individual training log for all staff is maintained by the administrative assistant / receptionist. Staff are required to attend training sessions even outside their normal working hours and are paid to do so and are disciplined if they fail to attend.

5.31 Staff at many levels confirmed that training is an important element in their working routine. The E&V team spoke to three care staff who talked positively about training, however an Activity Co-ordinator, had not received training to provide activities which promoted independence. She was however undertaking a longer course related to dementia.

**Provider response:**
The activity co-ordinator is registered with NAPA and hence has access to
5.32 The Deputy Manager told the team that no request for training is ever refused by the Operations Director and the carers spoken to by the team acknowledged that they had regular training in infection control and dementia which is updated annually. The team were told by the Deputy that if a carer had any concerns or issues that they wished to discuss they could approach the senior carer. This was confirmed by a carer the team spoke to who wished to discuss further training opportunities and planned to speak to the senior carer that afternoon. The Deputy is taking a structured NVQ course and has the support of a trainer providing one to one sessions. The Deputy was very pleased with her training.

5.33 The fact that much of the training is provided internally may be both a strength and a weakness as some greater exposure to other ways of doing things would be productive as most care staff spoken to by the team had only ever been employed as a carer at Magdalen House. The impact of training is undermined if, as the team later learned from some carers, supervision sessions are not held consistently, and planned sessions could be cancelled. One area where the team thought there may be a need for additional training is in the promotion of independence, the promotion of individual well-being and spiritual care which will be discussed later in the report.

b. The Experience of Residents

Introduction

5.34 So far this report describes the physical environment of Magdalen House, its facilities, the management philosophy and practice of those that run it and how the staff they employ are trained to carry out their tasks. This next section will look at the experience of the residents who live there and in more detail at the impact of staff care practices. The E&V team have not created a separate section for dementia care but comments about this are integrated into each aspect.

Care planning and assessments

As described above the home tries to carry out an initial care assessment in the resident’s own home or if necessary at the hospital before a resident comes to live at Magdalen House. This initial conversation, which the team were assured, is handled sensitively, and aims to include discussion about end of life wishes, some new residents have an agreed a palliative care plan at the point of admission. This may include any ‘Do Not Attempt Resuscitation’ (DNAR) instructions which are held in a ‘Yellow Folder’ kept in the resident’s care plan folder used by all carers. This was a good example of how personalised care can be provided. An initial outline care plan, usually drawn up by the Deputy Manager or Operations Director, is created at this point. A more detailed care plan, based on the actual experience and needs of the new resident is prepared at the end of two weeks residence. One resident demonstrated that he felt his care needs were met and said that bed times and getting up time was flexible and breakfast times would be adapted around getting up later.

Carers advised the team that there was a handover at the start of each shift which updated them on resident needs and any changes etc. If they needed further information or wanted to check on something related to that resident, then care plans and other documentation would be available to them in patient folders held centrally. The E&V team did not observe any documentation or recording of food intake.
Provider response:
Food intake is documented in the daily notes of the residents and food charts by carers.

5.37 If a resident’s behaviour changes after admission, perhaps by demonstrating the onset of dementia, they can begin visiting the dementia floor before they are gradually integrated on a permanent basis to that floor if necessary.

5.38 One resident was observed to have bruising to the right side of her head and it was explained that this resident was poorly sighted and had repeatedly declined support in moving around. Her needs were being assessed and care planned by the multidisciplinary team, including mental health colleagues.

5.39 There was an emphasis on resident of the day approach, but it was not clear what this amounted to, it may have just been a prompt to conduct a review of the current care plan?

Meals & choice

5.40 The five Healthwatch Suffolk visitors sat, individually, with groups of residents at lunch time and had a good overview of lunch arrangements and the experience of residents. It also provided an opportunity to engage in some natural and longer conversations with the residents about a range of subjects.

Providers response:
The team sat at residents’ table and a couple of residents felt they had no choice but to agree. As far as they were concerned the E&V team were strangers. They asked continuous questions while the residents were trying to eat their meal and two of them complained to staff about that.

Healthwatch Suffolk response:
The Enter & View team reported having engaging conversation with residents during the meal time. No objections were reported to the team. One of the key principles of an Enter & View visit is that teams are unobtrusive.

5.41 The E&V team were told that residents were asked by the kitchen staff for their menu choice the previous evening or at breakfast. Choice was normally presented orally, although a chalk board with the handwritten menu was available in the dining room but unfortunately the text was rather unclear. The team did not see use of picture menu cards. Those with dementia were shown a plated choice of two meals at lunchtime and a verbal description of this choice was shared with some residents, but not always.

5.42 More detailed resident wishes, or preferences did not seem to be known by the care staff who served lunch. Once a resident had indicated which meal they wanted from the choice of two meal options a standard plate of food was served. All portions seemed to be the same size with the same items on the plate even though some residents had previously said that they did not want something for example, potato. The portions all appeared to be large (as well as for the Healthwatch Suffolk visitors!) and appeared to be off putting to some residents with reduced appetite. One resident said “the large portions put me off. Smaller portions would be a lot better and then if someone is still hungry they can always ask for more”. Others commented on the large amount of food waste.

Provider response:
This feedback has been passed to the staff and they have been reminded to ensure residents have what they want to eat on their plate and in smaller portions.

5.43 The Healthwatch Suffolk visitors had a baked leek and bacon gratin with potato and swede. The other meal option was a ‘hash’ type meal where vegetables...
were mixed in with the meat. The Healthwatch Suffolk visitors felt that the food was bland, lacked texture and was unappetising in appearance but “adequate”, a word also used by one of the relatives who the team spoke to. They went on to say that staff were “excellent, kind and thoughtful”, describing the food as “very adequate”. He had no complaints about the home. The team asked about salad and fruit and were told that there was no fruit offered at breakfast. One resident said he had been handed a banana as pudding. One resident said that he could not remember the last time he had been offered salad.

**Provider response:**
We are sorry the visitor felt the food was adequate, but disagree with them as we tasted the food and found it tasty. We discuss the food cooked in the home at residents meeting and did so in our January meeting and again residents were happy and with the quality of food they had.

There is a basket of fruit available in the lounge for residents, however staff are now offering cut fruits to the residents, which some will eat and others don’t, which means that the fruit is wasted. Salad is always offered as a third option at meal times.

5.44 The E&V team saw no evidence of carers offering simple hand hygiene to residents before lunch. Serviettes were available on the tables and a minority of residents were supported to wear bibs. On the first floor those with dementia did not receive help or encouragement from staff to open these out and use them. However, when one resident became agitated at lunch time, staff were patient and caring, taking time to talk calmly and on the same level as the resident. The senior carer was particularly sensitive in her approach and ensured that other residents were not alarmed. Some encouragement and assistance to eat was observed for other residents and a person on one table was on a soft diet and had a member of staff with her most of the time to offer assistance if required.

5.45 Elsewhere one resident in a wheelchair was helped with eating his meal by an Activities Co-ordinator which led to a conversation about sailing which he enjoyed. One resident was observed to eat nothing despite being offered an alternative. Even with encouragement he did not eat anything at lunchtime, the team were advised that he was being monitored on a food and fluid chart and would be offered further food later in the day. Small glasses of squash were poured by the carers but water was not readily available. Medication was administered during lunch in a kind and caring manner by a designated member of staff in a labelled tabard.

5.46 When asked if they were able to influence the menu three residents, two of whom were very articulate and interested in their surroundings, said that they did not know how they would do this and one commented “less baked beans would be good for a start!” Several other residents said that they were unable to (or did not know how to) request items for the menu. One relative who regularly visited his wife told the team that he had no recollection of his wife or himself ever having been invited to a residents or carers meeting.

**Provider performance:**
As discussed before menus are discussed at residents and relatives meeting and if residents wish to have anything not on the menu they speak to the chef or staff.

Had the team looked at the menu, they would have noted that baked beans is offered only twice a week for cooked breakfast and with Jacket potato in the evening and not every day.
The report should be amended to reflect the changes made above under each section.

**Well-being, spiritual care & activities and resident comment**

5.47 Magdalen House employs three Activities Co-ordinators who complete a ‘This is Me’ exercise with each resident which is kept in their ‘Activity Log’. One of the Activities Co-ordinators specialises in working with residents on the dementia floor and another enjoys 1:1 activities with residents. She told us she planned to take residents to the remembrance service locally, but in reality, she is only able to take one person out at a time and this seemed to be an issue which restricted resident’s lives. Although the team were told that residents go to the local pub we did not meet anyone who could remember going there. The E&V team also spoke to a resident who was in bed with sore eyes. When asked if he had had an eye test he said “Never” and said he did not like to ask to go to the opticians as he knew that someone would have to go with him.

5.48 On the morning of the visit an art/paper activity in the dementia unit was being led by “Creative Mojo”, an external agency employed to support activities in the home. This session was advertised on small notices in the reception area and in the lift. The notice was in tiny text (less than 10 font) and had postage sized pictures of activities. There was also a larger activity notice board in the ground floor dining room which displayed one A4 sheet saying ‘Activities this week will include some of the following’ with no times or dates. This was not informative or helpful and did not comply with the requirements of the NHS Accessible Information Standard.

**Provider response:**

Religious services are held as well as other celebrations such as Halloween and Bonfire Night. On these occasions carers often come in during their off-duty time. The home also employs external entertainers, usually once during the week. One resident confirmed that she could take communion if she wanted to, although this was not something that she chose to do. This same resident liked to sew, knit and do gardening but since being in the home (a few months) she had not done any of the activities that she loved and wanted to do. She stated there was no opportunity to bake or to prepare vegetables.

5.49 There seemed to be a limited range of informal activities available to residents. The team noticed that a ‘reminiscence’ board was in the process of being developed by an activity worker with a resident but the team saw no evidence of “reminiscence boxes” containing items and photos being used or being casually available for residents and carers to dip into to stimulate conversation and memory. A carer commented “That would be wonderful” when this idea was suggested. However, the current level of staffing would challenge this happening.

**Provider response:**

As already stated above we do have reminiscence boxes/items which were put together by the families, which are currently used on the Dementia floor and staffing has not been a challenge to put this in place. The home is linked to Hadleigh Dementia Association and the activity organisers attend their monthly meeting and implement some of the ideas...
they get form there.

5.51  The E&V team were told that residents helped with gardening, however, raised beds in the courtyard and hanging baskets were uncared for and the team saw no evidence of residents gardening activity. One resident said the thing he missed most about living at Magdalen House was his garden and being able to get a breath of fresh air. He said he had not been outside for ages. He said he had helped in the garden and would like to do more but when asked about choosing bedding plants and bulbs he said he thought he just had to plant what was given. He said bulbs were not used. When asked about activities another resident only mentioned bingo and others the team spoke to could not think of any activity they enjoyed other than watching TV and listening to their radio.

5.52  The E&V team spoke to a small group of gentlemen one of whom had been a bricklayer, a cyclist and gardener and the other had been a carpenter and when the team asked what activities they would like to take part in they did not know but both became more animated talking about their working lives and where they used to live. One of these gentlemen was quite young in comparison to the other residents, but he never leaves the home.

Provider response:
We encourage our residents to participate in activities and some do and some say they want to but need encouragement to actually do any activities. Our residents also have families who visit them and take them out. The gentleman in question does go out with his family. We respectfully suggest that the E&V team shouldn’t let their feeling dictate a finding, they should instead find out what actually is factual.

Healthwatch Suffolk response:
The report is based on observations and comments received at the time of the visit.

5.53  Two other residents felt that they were only at Magdalen House because they had been through health problems which made it difficult to cope at home; they both would have preferred to be at home if they could. They did not feel that living at Magdalen House had enhanced their lives. They could not think of anything that they enjoyed other than watching TV in their own rooms.

5.54  Residents did not appear to be offered choices and the team wondered if, despite the availability of accredited training and off-the-peg policies, those policies were applied in a way which had a real impact on resident’s lives as they seemed to be rather detached from resident’s day to day needs.

5.55  For ground floor residents the only choice seemed to be to sit in the lounge or sit in their own room. The second floor is described as suitable for residents who are more independent but there did not seem to be any encouragement or support to enable a resident to retain (or acquire) independence skills. The E&V team asked a member of staff what would happen if a resident wanted to make a drink or snack and whether they would be able to do so and were told “No. A member of staff would do it for them”.

Provider response:
We have residents in the home who make drinks for themselves and are assisted to make snacks. I am therefore unsure why staff would make that comment.

5.56  Some residents said that they did not how they would buy clothes if they needed to and did not know how to shop on-line or how to use WIFI. However, the team learned from the Newsletter that a clothing company had visited the Magdalen House on 5th October and would return “after Christmas with
some new stock”. This demonstrates the importance of having “accessible information” provided in a way which meets resident’s needs.

5.57 One male resident on the upper floor who the team spoke to seems to spend each day in his room watching television which may be his choice, but the team wondered what efforts have been made to give him a broader quality of life. He described how he would like to make himself a cup of tea or coffee but said that even though there is a fridge and kettle in his room “they will not let me have any milk for this”. When, subsequently, this was discussed with a carer she commented that she was unaware of this but wondered if there may have been concern from the daughter for safety reasons. Another very capable resident who had a room on the second floor had been an active member of the Women’s Institute in another part of the country before coming to live at Magdalen House said that she does not like remaining alone up in her room all day and so spends every day on the ground floor with the less able residents. She clearly lacked intellectual stimulation.

5.58 Some residents with a degree of dementia said they did not like living at the home and wanted to be in their own home and commented “there is not much to do” and another, said “it’s OK”. However, the husband of one resident with quite advanced dementia said he appreciated the care his wife received and did not think there was anything to be improved.

5.59 The second floor has a room which is described as the ‘Bistro’ and ‘Cinema’ which did not seem to be integrated into the life of the home and was not part of the ordinary resources used by residents. This became clear from the comments of one resident the team spoke to who had moved into Magdalen House five months ago and did not know there was a ‘cinema’ as described in the brochure. He had not been to look at the room and did not know about any screenings. There was no evidence that residents were involved in choices of films or of music played in the bistro/cinema or any evidence of a regular programme of events/film showings.

**Provider response:**

The bistro is used by families and residents and the residents chose which film they will watch. It would be relevant to know which residents the team were speaking with as some of our residents do have cognitive impairment and do not remember what they do.

We will put activities and meals on the agenda of the next meeting with the resident and will discuss what they want to do and, we will include their choices in our activities and menus.

Magdalen House brands itself as a ‘Luxury Care Home’ and the brochure proudly states that; “the home provides a level of comfort and care that surpasses expectations for care homes. It is our attention to the details of people’s interests, desire and independence which sets us apart”. In the view of the E&V team, Magdalen House does not appear to be ‘luxury’ when compared with other places that brand themselves as ‘up-market’ and does not compare favourably with many homes in terms of the attention it gives to the “interests, desires and independence” of its residents.

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5.61 The E&V team felt that the design of the home presented challenges to the Provider which are difficult to overcome. The design is simple and functional and may have appeared to be efficient. However, having three floors without space for a communal lounge on each floor undermines the objective of enhancing the independence of the more able residents.

5.62 The concept of having a second floor
without having staff based on it seems to be out-dated for two reasons:-

- An increasing dependency of residents, including some of those on the “independent floor” needs to be recognised.
- Some of the more able residents do not wish to be isolated from social contact and as a result spend their time on the ground floor which then may become understaffed because of the increased number of residents spending time “on the wrong floor”. This compounds the call-bell response problems for residents on the second floor.

5.63 There was evidence that training had an impact on the way staff related to residents with dementia. However, the impact of policies and training seemed rather detached from the needs of the more able and independent residents. There was no evidence that the promotion of independence had achieved a positive and direct effect on lives.

5.64 Residents seemed to have little opportunity to influence what was on the menu, the size of portions or the specific items served as all servings seemed to be a standard size. Several residents said the portions were too large and some were concerned about the large amount of food waste.
Areas of Good Practice

6.1 Pre-admission conversations at the person’s home clearly happen – the team were provided with a significant amount of detail on how they are conducted. These initial conversations are handled in a sufficiently sensitive manner that enables there to be a discussion about end of life wishes. This was a good example of how personalised care can be provided as required by the AIS (NHS Accessible Information Standard).

6.2 The Operations Director has created a management monitoring system with a structured framework of Key Performance Indicators (KPIs) which require the production of weekly and monthly management service provision reports including complaints, staffing and staff retention, occupancy levels, safeguarding and falls amongst other matters.

6.3 There is a system of regular meetings between the Manager and Senior care staff and between the Manager and carers is held on a monthly basis. There is a cascading system of supervision to individual carers.

6.4 The company (Alysia Care) uses external agencies to support its strategic framework which ensures policies are up to date in order that the Home is compliant with the law and CQC procedures and requirements. These policies are reviewed every year.

6.5 Staff at various levels confirmed that training is a regular and important part of their working life at Magdalen House. This is a priority for the management of the Home which is reinforced by the fact that basic training is mandatory and there are sanctions for non-attendance. Higher level training is offered to more senior staff.

6.6 There is a sympathetic and sensitive way of monitoring a resident’s behavioural changes and needs after admission if they show signs of needing dementia care.

6.7 Staff were patient and caring with residents who had dementia. The senior carer was particularly sensitive in her approach and ensured that other residents were not alarmed by a resident’s behaviour which might have caused concern. Another example was the support provided by a bi-lingual Portuguese carer to a Portuguese resident with dementia who does not understand English.

6.8 The Manager and care staff have established a regular pattern of meetings with the community based multi-disciplinary team, including mental health colleagues to assess and care plan for residents changing needs.

6.9 The company has now established a stable core of staff and no agency staff have been employed for over one year and have been able to cover staff vacancies, sickness or absence with their own staffing compliment.

Recommendations

These recommendations include actions which do not need to be time consuming or costly and some could save money and reduce waste; others will improve the quality of life of residents.

6.10 Action needs to be taken to improve the well-being and spiritual care offered to residents. The team came away from the visit feeling extremely sad that so many
residents appeared to be 'existing' in the home on a day to day basis without the opportunity to go outside, engage with the community, or take part in any stimulating activity. The team provided the Proprietor with a copy of the Healthwatch Suffolk report on "Spiritual Care" and recommend that due attention is given to the examples of good practice in that report. Members of staff should be given opportunities to visit other homes to gain an insight into how meaningful activities, good spiritual care can be delivered and individual needs met. Truly person centred or individual care requires more than providing a clean, modern and supportive environment which meets KPIs set by a proprietor. The term 'luxury care' is used by the proprietor to describe the home however luxury care needs to be more than providing an environment where physical care can be provided.

6.14 Hand hygiene for residents and carers, especially at meal times should be improved and hand hygiene dispenser points for staff or visitors should be provided at key points in the building to reduce the risk of infection.

6.15 Residents and, where relevant, their families should be given more opportunities to exercise choice and control, for example in relation to activities or food for example by the use of menu cards and greater consultation on the menus themselves. Residents and relatives meetings should be held on a regular basis and should be advertised in an effective and accessible manner.

6.16 There should be better engagement and integration with the community for example by the recruitment of "friends" or volunteers who could support the Activities Co-ordinator and other staff to help the residents to become more integrated with the community, for example by visiting some of the nearby shops in the High Street. Volunteers may also assist with the promotion of activities in the Home. There may be groups in the community who would also be able to help or which some of the more able residents could join.

6.17 The adjacent Day Centre, which is separate to the main service offers potential additional space of a large room with pleasant furnishings. It is accessible from the ground floor of Magdalen House. The day centre attendees leave at about 1500 hours at which time outside groups such as a local history group, craft club, singing or choir groups could be encouraged to use the room. These groups might be of interest to Magdalen House residents, giving them more choice of activities.

6.18 The requirements of the NHS Accessible Information Standard should be considered in relation to all communications...
for and about residents. An information leaflet was left with the Home Proprietor.

Summary & Conclusions

6.19 There are areas of good practice as described but also serious short-comings some of which have been identified in body of the report and the recommendations made, these need to be addressed.

6.20 The culture of the home is one dependent on the selection, appointment and training of sufficient staff, reporting KPIs, internal monitoring of performance and close supervision of managers and senior staff. The relationships between carers and residents seem to be good.

6.21 There is a lack of imagination in the way residents emotional and spiritual needs are met. Truly personal or individual care requires more than providing a clean, modern and supportive environment which meets KPIs set by a proprietor. The term “luxury care” is used by the proprietor to describe the home however luxury care needs to be more than providing an environment where physical care can be provided.

6.22 It may be thought that this report overly concentrates on negative comments from residents, but the E&V team can only report what they have heard. The E&V team have not ‘censored’ positive comments and have reported faithfully what residents told the team.

Provider response:
We believe that this report is negative, and this was proven by the introduction of why this visit was organised. We believe this is based on opinions of lay people and not people experienced in dealing with residents with different needs and conditions such as Dementia.

Healthwatch Suffolk response:
Enter & View visits and subsequent reports are completed by Healthwatch Suffolk volunteers who are recruited specifically for the role of Enter & View ‘authorised representatives’. Most of the volunteers are from a health or social care background. The volunteers undergo specific training for the role of authorised representative.

Please see Appendix A which contains short biographies of the five experienced volunteers who were involved in this visit all of whom have a health or social care background.
Verbatim, provider comments are included within the text of the report. Any action plan submitted by the provider will also be attached to the report.

The providers responses have been included within the body of the report. These are verbatim and in red.

Enter & View reports are records of observations made and comments received, during an Enter & View visit to the service.
Lead Authorised Representative: David

David has a degree in sociology from Essex University in 1972 and qualified as a Social Worker with an MA in Applied Social Studies from Warwick University in 1975.

David worked in social care in Suffolk and Essex since 1973 and held a variety of social care management posts across the County including Health Team Manager at West Suffolk Hospital, Locality Manager in Ipswich and finally Head of Access and Partnerships, a countywide role.

David left Suffolk County Council in April 2011 and from October 2012 led a team of volunteers to set up Healthwatch Suffolk (HWS) and became its first Chair in April 2013. David resigned as a Director of Healthwatch Suffolk in October 2016 and in November 2016 became Chair of the Trustees of The Befriending Service (TBS) a charity principally for people with Learning Difficulties.

Team of Authorised Representatives:

Helen is a Senior Lecturer in Nursing, currently working part-time at the University of Suffolk with one day per week spent supporting student nurses and their mentors at Ipswich Hospital NHS Trust. She has a Masters degree in nursing and is a Registered Nurse Teacher with a background in nursing and nurse education of over 30 years. Helen has published widely, and has been a national speaker on tissue viability issues.

Joanne is a qualified property surveyor and housing management professional with many years’ experience at senior (including board) level in both the affordable housing sector and the private rentals market. She has been housing manager of many types of housing schemes including very sheltered housing schemes, leasehold schemes for the elderly as well as management of the homes of elderly residents living in the wider community.

Stella is a Senior Client Service Manager. She has worked in housing support for 30 years in various roles the last 16 years have been in Floating Support. Stella has supported a diverse range of service users including those with mental ill health, learning disabilities and dementia. She is a dementia friend and staunchly believes that all users of services should be encouraged and supported to be as independent as possible for as long as possible.

Steve is an experienced strategic and operational manager in social care and has been a Director of Adult Services, and Regional Director with the Social Services Inspectorate. He is a qualified social worker, Knowledge Transfer Fellow with the Institute of Public Care at Oxford Brookes University and is a Director at Healthwatch Suffolk.
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You can watch a short video about us via the following link: www.healthwatchsuffolk.co.uk/about-us/

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Write:
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For information about how we made a difference in the year 2016/17, please download our annual report from:
http://www.healthwatchsuffolk.co.uk/about-us/annual-reports-and-agm-resources/

You can also contact us for a hard copy (limited availability) or watch our supporting video. Simply search for “Healthwatch Suffolk” on YouTube.

If you require this report in an alternative format please contact us at the address above.

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