The Orders Of St. John Care Trust

OSJCT Athelstan House

Inspection report

Priory Way
Burton Hill
Malmesbury
Wiltshire
SN16 0FB

Tel: 01666848000
Website: www.osjct.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

OSJCT Athelstan House provides nursing and residential care for up to 80 people. In addition to long term care, the home offers short stays to people who require support with rehabilitation or a period of respite care.

This inspection took place on the 17, 18 19 and 23 May 2017. The first day of the inspection was unannounced and the manager was aware of subsequent visits.

A registered manager was not in post. There had been several changes in managers in a 12-month period. Staff said there had been five managers. These changes did not enable the staff to clear guidance and leadership. 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.

People said the staff and the security of the building made them feel safe. Some of the staff we spoke with said people were not safe. These staff said they were not delivering adequate levels of care at all times. Staff said they did not felt confident to raise concerns to the provider, as they felt their concerns were not taken seriously. During the inspection, 11 staff came forward to raise concerns about the service.

People were at risk because information and record keeping was inconsistent. Staff said identified risks were assessed and action was taken to minimise the risk. We saw that risk assessments lacked detail and action plans were not followed. Where people had capacity to make decisions and were refusing textured diets, risk assessments were not developed and agreements were not reached on the foods to be eaten. Where people's fluid and food intake was monitored the charts were not analysed or totalled at the end of each day. This left people at higher risk of dehydration. People were not supported to move position according to the risk assessment which meant they were at higher risk of developing pressure ulcers.

People expressed concerns about insufficient staffing levels and lack of effective management in the deployment of staff. They said at certain times of the day, they had long waits before help arrived. Documents provided on staffing levels indicated that in 12 months, 31 staff had left the service which included registered nurses, seniors and carers, housekeeping and catering staff. The staff raised concerns about the deployment of staff.

During our visit we noted the call bells ringing. Staff told us their hand held devises were not working effectively and they were not always aware of people summoning them for attention.

Staff expressed concerns about training. Staff said training was often cancelled and there were times when they were not able to attend as there were insufficient staff on duty to maintain staffing levels.

One to one meetings were not taking place and staff felt there was a lack of opportunities for personal development. Staff told us one to one meetings with their line manager and appraisals were not taking place. Registered nurses were not supported to maintain their registration. They said a re-validation programme was not available for them to maintain their registration.

The care plans we looked at were inconsistent and were not updated following the reviews. We found care plans were task led and had little information about people's preferences on how people liked their care to be delivered.

Relatives were aware of the complaints procedure but were concerned that little happened when they raised a concern.
While a member of staff said their units ran smoothly and a unit lead was available for support and guidance, other staff told us there was conflict between staff and there was little support from managers. The head of care agreed there was a lack of leadership on the nursing units and the RGN's were being helped to delegate with the introduction of allocation sheets."

The management of medicine systems were not consistently effective. Members of staff were not signing for the administration of topical medicines. Protocols were not in place for the application of when required (PRN) topical creams and ointments.

We found parts of the home dirty. Cleaning schedules were not always completed.
An infection control audit had taken place on the 3 November 2016 and areas for improvement were identified. For example, "chairs need a good clean, carpets need cleaning and staff need to be reinforced they need to wash their hands." A follow-up audit had taken place and some improvements had taken place.

Peoples' opinions on the food was varied and was described as "exceptional", "good" or "variable", depending on who was cooking it. All staff we spoke with raised concerns about the quality of the food. There had been shortages of catering staff January 2017. We saw that the meals were not provided at the time people expected them

Reports of visits showed that people had access to specialists, GP's and they had regular check up with the dentist and optician. The feedback from healthcare professional based at the service was generally positive about the staff.

The people we spoke with said the staff were kind, caring and well trained. We saw examples of staff supporting people in a kind and compassionate manner. However, we also received feedback from people that staff were not always caring

The rights of people were respected. Staff said people were assigned keyworkers. people dignity was maintained. Staff were aware of the day to day decisions people were able to make. Staff told us people made decisions about their meals, what they wore and activities.

The Athelstan House Improvement Team was introduced by relatives with the support of the manager to provide regular feedback of the quality of care delivered to their family members. We noted from the minutes of the meetings there were open discussions about staffing levels and the quality of the food.

Quality Assurance systems were in place to assess and monitor the standards of care delivered at the service. The standards of care were assessed against legislations and shortfalls were identified. An action

plan to drive improvements was developed but action had not been taken to meet standards. Following the inspection, we met with the regional management team to discuss our concerns. After the inspection, the management team sent us action plans on how they were going to address the shortfalls.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Despite people telling us the staff and the security of the building made them feel safe the staff did not feel people were safe. They said the staffing levels and the equipment used by people to summon assistance prevented them from delivering safe care.

Risks were not always identified and risk assessments and action plans were not consistently followed to minimise the risk.

Medicine systems were not signed for the application of topical medicines and protocols were not developed for the application of when required (PRN) topical medicines.

The premises in particular the kitchen were not maintained to safe infection control standards.

Is the service effective?

Requires Improvement

The service was not effective.

People, relatives and staff raised concerns about the quality of some of the meals.

Staff raised concerns about the training and the opportunities for them to access training. Staff were not able to benefit from regular one to one meetings with their line manager. Appraisals were not taking place for staff.

Staff enabled people to make day-to-day living decisions.

People were supported with their ongoing healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us the staff were caring but concerns were raised about the caring nature of some staff . The staff we spoke with knew the importance of developing positive relationships with people.

The building was designed to enable people to move around freely around the property and to access the upper levels by a lift.

Staff provided care in a way that maintained people's privacy and upheld their rights

Is the service responsive?

Requires Improvement

The service was not responsive.

The care plans we looked at were inconsistent and were not updated following the reviews.

People and relatives said they were able to raise concerns. Relatives were aware of the complaints procedure but were concerned that improvements did not take place when they raised concerns.

An activities programme was in place and people were able to participate in group activities. Where people preferred one to one activities, these were organised.

Is the service well-led?

Requires Improvement

The service was not well led.

A registered manager was not in post.

Staff had identified areas of poor leadership and management. Relatives had given feedback through meetings and had raised concerns about staffing levels and the quality of the food.

Quality assurance systems were in place and the findings in some areas identified for improvement were consistent with inspection findings for improvements.

OSJCT Athelstan House

Detailed findings

Background to this inspection

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

This inspection took place on the 17, 18, 19 and 23 May 2017 and was unannounced on the first day of the inspection. At the time of the inspection there were 74 people living at the service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by one inspector, inspection manager, specialist advisor and an Expert by Experience. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.

We spoke with nine people and four relatives about their views on the quality of the care. We spoke with the manager, deputy manager and eleven staff including agency staff. We also spoke with the chef and activities coordinator.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included five care plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and explained what keeping safe meant to them. One person said, "staff are remarkably kind, helpful, and cheerful. There is great kindness; I have never seen any unpleasantness" and "feel I am safer. I like it because it is my own place. It is lovely. I have friends [other people and staff] around. Before, I was living on my own, it was not so nice."

The staff were able to describe the procedures for safeguarding of vulnerable adults from abuse. They knew the types of abuse and the expectation placed on them that they should report abuse. However, not all staff said people were safe and that they did not always feel confident reporting their concerns to the management at the home. Three staff said they worried about people and one staff said, "I go home and I cry. I do not feel I do a good job. I feel guilty because I cannot do things properly."

Staff said they felt confident to raise concerns externally but did not always feel confident to do this to the management of the home. During our visit, three staff told us that at a recent staff meeting they were told, "CQC are coming and that they were to portray that they were not understaffed and that they had all the required equipment." Another member of staff said, "We have been gagged not to say the truth, but we will tell". 11 staff came forward during the inspection to raise their concerns about the service. The concerns staff told us about mostly related to staffing levels, equipment and the quality of the food.

The feedback from staff demonstrated that the systems and processes in place to safeguard people from potential improper treatment or abuse were not working effectively.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to identify risk however, these were not always robust. For one person the eating and drinking care plan dated '6.December 2016 stated they had dysphasia [difficulty in swallowing]. The plan stated that the person had refused to eat the appropriate meals and drink thickened fluids. The GP notes dated 9 February 2017 stated, "Goes against advice and refuses to have drinks thickened." An action plan had been developed to address this issue, which included the guidance on the first aid to be given in the event of partial or full air obstruction and the position the person should be in when eating meals. We noted, however, that not all the information gathered about the person's refusal to accept advice was included in the care plan, for example, information such as refusal to have thickeners in drinks. We found that staff continued to serve foods which would be considered as high risk and increase the risk of choking. Agreements had not been developed on how staff were to support the person with these high risk foods. There was no evidence that discussions had taken place to assist the person to agree to eat lower risk foods. A member of staff said they ensured the person was sat upright and assisted the person to eat their meals. Another member of staff said the person refused thickeners in drinks and that this person was able to make choices about meals.

The food nutrition record dated 19 May 2017 for one person showed all offers of meals were declined and on

that day the person's fluid intake was 100mls. For another person on 21 May the food nutrition record showed the person ate half a slice of toast for breakfast and half a sandwich for lunch and had drank 370 mls of fluid. We saw no evidence that action was taken including relaying this information to the staff in charge. This meant staff were not aware of people's intake of fluid and they were at greater risk from malnutrition.

Two staff said information about people's poor intake of food and fluid was relayed to senior staff but "nothing is done. Nobody [senior and above] checks the charts." Staff said information on people's current needs was passed on during handovers and handover sheets had up to date information about people recorded. Daily records within the care plans did not include information about people's poor food and fluid intake. We read on the handover sheet for one person which stated "low BMI [Body mass index combined height and weight] on food and fluid chart, push fluids". There was no information or evidence that this information was not in the care plans nor that the care plan had been reviewed as a result. There was therefore no clear guidance to staff on the care needs of these people.

We looked at the repositioning charts for one person at risk of developing pressure ulcers. The care plan stated that this person was to be repositioned every four hours to prevent pressure on specific areas of the body. On the 21 May this person was repositioned at 11 am and not again until 6pm. On the 22 May the repositioning chart for this person showed they were repositioned at 10am and not again until 5pm. This meant this person was not repositioned four hourly as detailed in the care plan. We noted from the daily reports that this person was found on the floor at 5:20pm on the 21 May. The three staff we asked who were on duty at the time confirmed the person had not been repositioned until the person was found on the floor. The repositioning chart was therefore inaccurate. For another person the tissue viability care plan instructed staff to reposition the person four hourly but the review notes stated the person was to reposition the person hourly. We asked the manager about this but they were unaware of the repositioning frequency for this person. This left people at increased risk of developing pressure ulcers.

This was a breach of Regulation 12 (a) and (b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Moving and handling risk assessments were in place for people that needed assistance from staff with mobility. The equipment and the number of staff needed for each movement was in place. Where people needed equipment such as hoists the size of the slings used was included in the assessment.

Falls assessments were completed to assess the level of risk for people with a history of falls. For example, people that had issues with balance and were unsteady with walking were assessed at high risk of falling.

Individual fire evacuation plans were in place, which gave staff information on the number of staff and equipment needed for a safe evacuation of the property.

We were provided with a report from the home manager on the number of staff that had left employment within the last 12 months. We were told and the record confirmed registered nurses, seniors and carers that had left the service. Bank staff, housekeeping and catering staff had also resigned. This meant 31 staff (equating to a minimum of 452 care hours) had left 12 months and there was reliance on agency staff to maintain staffing levels.

A member of staff said the staffing level on their unit was one registered nurse, two agency and two permanent staff on duty during the day. They said "sometimes we go below the staffing levels." They said "I don't cut corners, all the people in the unit will receive personal care and I won't be rushing either". Another

member of staff said "there is pressure to rush. We are leaving people half washed because the bells [call bells] are ringing and we have to answer them".

People were at risk from unsafe staffing levels and from the lack of equipment needed for people to summons support from staff. The 11 staff that raised concerns to us said staffing levels and agency staff were not always used to maintain the staffing levels.

People told us that, at certain times of the day, they had long waits before "help" arrived. The comments from two people included "I am quite often stuck waiting on the toilet" and "some people who need help have to wait a long time." Other people said the level of attention from staff was variable and people had to wait when staff changeovers occurred. One person said staffing was "good at certain times, when they change over shifts there is a delay. Staff do come and explain delays. They are not usually serious delays", another person said, "If I press bell, staff get to me quickly. I have never had to wait a long time".

A relative told us their family member had lost skills and was not supported to maintain their independence since their admission to the home. They said their family member was fully continent but because staff support was not provided, they were not longer continent. This relative also stated "Another thing. It does say in her care plan to get her up out of bed but I have found her still in bed late afternoon. I have raised it but it is difficult to get anything done". Some staff showed concern about the personal care people received. One member of staff said, "There are times when people downstairs have not had any personal care until 3pm." Another member of staff said there were "odd times when people were not receiving personal care until late afternoon." Another member of staff said, "I don't know if the people in Lavender unit have baths or showers."

We noted that agency staff were used to cover some of the vacant hours. However, vacant hours were not always covered and during the inspection we saw that staff were asked to work in other units to maintain staffing levels. On Monday 22 May 2017, a member of staff told us the shifts were not covered despite managers being told in advance of the hours that needed covering. Instead of the 'normal', two care leaders being on duty, there was only one and that this staff member had to cover two units, which included the administration of medicines for 39 people. They said the staffing levels were two carers and one care leader on each unit. However, we noted that there were three care staff and an additional care staff member on induction shadowing staff who should not have been "counted in the numbers". The care leader said the activities coordinator was to cover until 5pm and a night care staff was going to cover from 5pm until 10pm. The head of care said the activities coordinator also worked as a 'carer' and had the necessary skills to deliver personal care. This meant while direct care was provided the provision of activities was reduced.

One person told us that they felt that the staffing was improving. They said, "the rest of the care is getting better. I moan sometimes about them being short-staffed and having a long wait. One day a chap was calling out 'I've fallen down; no one was coming so I rang to get him assistance".
Following the inspection, we spoke with the senior management responsible for the running of the service to express our concerns. The assistant operation director developed an action plan, which included an assessment of staffing levels. We were told dependency levels were to be reviewed and staffing levels were to be adjusted to meet current dependency levels.

During the inspection we saw that the equipment used to summon staff was not working effectively. Staff told us the call bell system used by people to gain support from staff did not work effectively. They said the system was failing and this had happening for over 18 months. A member of staff said "the battery for the phones is always a problem."

We also observed an incident where the call bells were ringing for a period of time. The care leader went to investigate why the staff had not responded to the nurse call. Three staff told us there was one hand held devise between the staff and this devise was not holding the charge which meant they were unaware that assistance was needed. We asked the head of care and manager to tell us when the phones were to be repaired. The head of care said the hand held devises had been tested and were holding their charge for the full length of the shifts. At 15:40 two staff said there was one handheld devise between them and there was one bar of charge left on the devise. They said unless the devise was charged there would not be sufficient charge to last the shift which ended at 8pm.

Following the inspection, we spoke with the senior management responsible for the running of the service to express our concerns. Following the inspection, we were told that the call bell system had been upgraded.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine systems was not safe in all areas. Staff were not signing Medicine Administration Records (MAR) correctly for medicines administered and for the application of topical creams.

Body maps were used by the staff to indicate the location on the body for the application of topical creams and ointments. A care plan on the application of topical creams and ointments was not in place for all the people prescribed with topical creams and ointments detailing when and where the creams should be applied.

A local pharmacist visited the service to undertake an audit of the medicine systems in November 2016. The report of the visit identified some areas for improvements which included duplication of items of MAR charts, missing signatures to indicate if medicines administered and medicine procedures were not actively used. During the inspection we noted there continued to be a duplication of prescribed medicines.

Risk assessments were completed where people had made the decision to self-administer their medicines. We saw for one person the GP was consulted and had agreed with the decision for self-administration of medicines. The GP had advised that staff were to monitor the person's competency and ability to self-administer their medicines.

People were not protected at all times from the risk of poor infection control measures. We found parts of the home dirty. The tracking on the lift doors had loose particles and debris and the upstairs carpets were dirty. The hot trolleys used to transport food in all units were dirty and the freezers in four units were dirty. The food trolleys had dried liquid and food debris inside and out. The shelves of the hot trolleys had dried food and liquid and were greasy to touch.

The kitchen was dirty and the freezers had a build-up of ice. The floors in the freezers and chiller rooms were dirty as well as stoves and deep fryers. The freezer room was disorganised. When frozen foods were taken from boxes we found half opened boxes on the floors and on shelves.

The staff had completed an infection control audit dated 7 March 2017. This had identified that cleaning schedules were missing, fridge and freezers were dirty and the inside of microwaves were dirty. Also identified within the audit was that aprons and tabards were stained and "left hung up dirty in kitchenettes". Despite this audit, on the 19 May, we found issues continued. We saw crumbs on the floor in the kitchen. We asked about cleaning schedules and until the week of the inspection week staff had not been given the

schedules. Staff had signed the forms on Sunday, Monday, and Tuesday for the cleaning of the waste disposal, waste bins, chopping boards, sinks and work surfaces. The form had not been signed for the Wednesday, Thursday and Friday. During the inspection, we asked the manager to accompany us to the kitchen to show her our concerns.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An infection control audit had taken place on the 3 November 2016 and areas for improvement were identified. For example, "chairs need a good clean, carpets need cleaning and staff need to be reinforced they need to wash their hands." A member of staff told us an additional infection control audit had taken place on 7 March to assess the improvements from the previous audit. The overall score for the home was 75% of standards met which meant there had been improvements with the overall hygiene standards.

Following our inspection the Assistant Operations director, produced an action plan from our feedback. We were told a "review had been completed following a visit from the department of Environmental Health. Actions identified internally and externally have been implemented to include higher staffing and skill mix within the home's catering department".

Requires Improvement

Is the service effective?

Our findings

The comments from the people about the skills of the staff included "permanent staff here excellent, they know how to care for us. The agency nurses are not good," "staff know me. They know I like to get up around 7.30. I can go to bed anytime," "I know quite a few of the staff, the agency staff are not quite sure what to do" and "good regular staff, they know how to care."

Staff told us that cover was not always organised which meant they were not always able to attend the training. Staff felt that there was little opportunity for personal developments. A member of staff said that "staff lacked insight into the needs of people living with dementia and Parkinson's. They said, "staff don't understand that people living with dementia have mood changes. I went in the office and told them about these staff."

Staff said training was often cancelled. One staff member told us that on one occasion, it was organised outside their working hours but they were not told about the training being cancelled before their arrival. They also said when it was arranged during their working hours and they were not able to attend as there were insufficient staff on duty to maintain staffing levels. A member of staff said the induction for nurses was poor and there was no competency framework for nurses or personal development. They said the organisation was "out of their depth" when it came to clinical training. The nurses told us that there was no re-validation programme in place for them. This meant the provider could not be certain that the nurses were competent to undertake the nursing procedures required by people.
We asked the manager for the homes training matrix during the inspection but this was not provided.

Staff said one to one meetings and appraisals with their line manager were not taking place. Regular meetings are not taking place and there is no opportunity for reflective learning." We looked at the files of two nurses. The personal development action plan for one staff dated 17/06/2015 included leadership and management learning. The second nurse had not had any personal development opportunities but there was one supervision session on 17/02/2015. No other records were seen.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The comments from people about the meals were variable and their comments included "The meals are very good, you can't fault them. I like most of the food, I know somebody who doesn't like the food so they do him beans on toast", "they do a great spotted dick and the faggots are excellent" and "if you wake up in the night and you would like a snack they will supply this need".

Negative comments about the food included "I think that the food is very good but varies. I had a guest come for lunch one day and unfortunately the food was frightful", "The meals are not good" and "the food could be better. The chicken is tough, there was no sauce because it had run out," "The food, sometimes it is good, sometimes not. I have a job to cut the meat sometimes."

All staff we spoke with raised concerns about the quality of the food. Staff told us the menus displayed on the units were different to the menus used by the catering staff. The head of care agreed that staff were not given access to the new menus as they needed more "tweaking" as some meals were repeated and the meals had to be changed. A member of staff said "I sneaked in the kitchen and got some fruit. I made fruit salad. They loved it." A relative said "Everyday its yogurt for the people who require soft diets. I just went to the supermarket and spent £10.00 on food for my husband." Following the inspection the provider agreed to discuss this issue with the relative to ascertain the likes and dislikes of the person and agree some alternative puddings

Staff told us the lunch time meal was at 12:30 and said the meals were often served late. We observed meals were served in the dining room after 1pm. People in their rooms were served after the dining rooms. This meant the people in their rooms had to wait until after 1pm for their meals.

Catering staff said their role was "stressful". They said there were shortages of staff since January 2017. The catering staff said on the 18 May the lunch time menu was for Roast Lamb and Spaghetti Bolognaise. They said on that day one cook was on duty and they had to make breakfast and cook two "hot meals" for lunch as well as preparing the tea. One member of staff said often there are two staff for cooking and washing-up for 80 people. Another member of staff said the day before one member of staff was in the kitchen preparing and, cooking while the bank [temporary staff used when needed] cook did the washing up. They said at the weekend the activities coordinator was rostered to help in the kitchen. The head of care said this member of staff had kitchen assistant skills. This meant schedules were not being maintained because regular staff were not employed to work in the kitchen.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The comments made by people about the support received from staff to make decisions included "I always feel free in the place, never bossed about," "staff always asks for my consent. If I do not want something, I do not do it. Staff never push," "choices, I do what I want to do, knitting, reading, joining in or not joining in" and " I am not stopped from doing anything, except from a health and safety point of view".

People were asked to sign consent forms to share information and for photographs to be taken. MCA assessments and best interest decisions were reached for specific decisions. However, documentation for one person was confusing on the legal powers obtained by relatives to make decisions. For example, a best interest decision dated 5 August 2015 stated relatives had power of attorney for finance but the advanced decision dated 14 April 2014 stated the relative had power of attorney for health and welfare. We looked at the MCA assessment for one person who refused to eat textured meals. The MCA stated that the person had capacity and was told they would not be resuscitated if they choked as a Do not attempt resuscitation (DNAR) was in place. We spoke to the GP who said this was not accurate. The staff were to render first aid if the person was to choke.

Staff were aware of the day to day decisions people were able to make. Staff told us people made decisions about their meals, what they wore and activities. A member of staff said people made decisions about their personal care and financial decisions. They said people's capacity was assessed and where they had capacity, the decisions taken were respected even if these were unwise decisions.

We saw that for some people DNAR orders which the GP had signed after consultation with family and the person were in place. Some people had made advanced decisions before their admission to the home.

Records of visits from healthcare professionals were maintained which showed people had regular visits from a GP. Reports of visits showed people had access to specialists and to community services such as the mental health team, district nurses. People had regular checks from opticians and dentists.

Requires Improvement

Is the service caring?

Our findings

Peoples' views on the standard of care varied they said regular carers were kind, caring and provided good quality care. Comments made by people included "The staff are remarkably kind, helpful and cheerful," "The staff are very kind help me out with things I can't do any more, " "the staff are absolutely fine" and " The staff, I love them a lot. Oh yes very kind and cheerful-very nice". One person said, "The nurses in particular are good, they have an understanding of peoples' requirements. No shortage of aid or assistance."

The comments made by relatives included "staff are amazing but they don't get support from the higher management,"

People also made negative comments about the attitude of the staff which included "concerns about one or two of the staff." Other comments included "Generally good but some come in the middle of the night and say what's wrong now" and "I complained to the head of care. Three nights running carer did not know how to do the bedpan. Wet clothes, sheets- bed had to be stripped, clean sheet, not very good." Relatives said, "The nurses are defensive - get upset when you mention anything, won't talk to you."

We saw examples of staff supporting people in a kind and compassionate manner. For example, we saw staff use dance steps to help one person take the necessary paces to reach the table. The member of staff was saying "one and two and one and two". Staff ensured people were able to make a choice about the meals. We saw staff take their time to ask people what they wanted to eat. Throughout the day, we saw a choice of hot and cold drinks being offered to people.

The staff we spoke with knew the importance of developing positive relationships with people. A member of staff said, "we chat and help people with personal care. We listen to people. We close doors and cover people when delivering personal care." Another member of staff said they respected people's rights. They said some people made the decision not to have relatives present during reviews and staff respected these decisions. This member of staff also said maintaining people's dignity and independence showed to people they mattered.

Another member of staff said people were assigned keyworkers. They said "making sure we speak to people when we are on duty to build a rapport." They said one person living with dementia did not remember their name but when they entered the bedroom this person said "I know you don't I." This member of staff said, "I try my best to give personal care. I talk about the things that interest them. I know about their likes and I remind them about fun times. I speak about their photos. We sing during personal care."

People made the following comments about the way staff respected their rights. They told us "privacy is respected. They will knock on my door, say who they are and close it behind them," "never hear them discussing another person" and "treat you with dignity when you shower".

Relatives told us they regularly visit at different times of the day and night and that there are no restrictions around visits. We saw relatives and friends had unrestricted access to their relatives residents in their rooms

so that they could visit in private.

The building was designed to enable people to move freely around the property and to access the upper levels by a lift. Toilets and bathrooms were clearly labelled with pictorial signage and murals and memorabilia help with people with orientation. There was natural daylight and good artificial lighting to help to create a safe environment for those people living with sight impairment. The building was secured with a keypad to prevent unauthorised entry. The garden was secure and planted with flowers, providing a stimulating environment for people.

Requires Improvement

Is the service responsive?

Our findings

People's care and support had been assessed before they started using the service. Assessments we viewed showed people had been involved in discussions about their care, support and any risks that were involved in managing their individual needs. People and their relatives told us they had been involved in the initial assessment.

People's comments about care planning was variable. One person told us the staff were aware of their routines. Other people told us "I have a care plan. They have a way of making you feel that you have devised the whole thing. It is in my care plan and they know that I am not allowed to get out of bed by myself and that I have a choking risk and I must have somebody near me when I am eating," and "totally involved with my care planning by the previous nurse but she left. I have been asked to look every two months. " However, some people said, "I am not involved in my care planning" and "know that I have a care plan but don't get to see it."

We found that monitoring charts were not always fully completed. A member of staff said people at risk of pressure ulcers were repositioned regularly and pressure mats in bedrooms were used for people with a history of falls. Monitoring charts were not consistently completed, lacked detail and were not analysed. This left people at a higher risk of developing pressure ulcers and of falling.

Information about people's healthcare needs was not passed on by staff from shift to shift. Staff had documented on 17 May in an acute care plan that for one person at risk of skin damage, a new area was seen while dressing another area of the foot. Staff had recorded a description of the wound, the size of the wound and that "this was dressed last night but had not been handed over."

"All about me" booklets were in place for some people. Their preferred first name, background histories and family relationships with preferred routines and activities were included in the booklets. The information about people's preferences were not used to develop care plans.

Staff had little insight into people's preferences and lacked an understanding on developing care plans and about the reviewing process. For example, the emotional well-being/mental state cognition care plan for one person informed staff that the person was able to make decisions and choices. The action plan was for staff to enable choice and offer reassurance when staff observe signs of anxiety. The action plan did not give staff guidance on how they were to identify signs of anxiety. The reviews notes were unrelated to the care plan as the review on the 12 May took place at midnight and stated "XX [name of person] chatty, enjoys TV and listening to music. Much settled at present".

Staff told us care plans were not up to date. A nurse said on their unit "care plans will not be up to date. It's a non-starter to keep them together". Three staff on one unit made the following comments "I can't review my care plans because they need updating. I prioritise and its people first," "they are not specific. I could not tell you what the 12 care plans are. I could not put them in order. I know daily reports, weights and continence. I know it's my responsibility I need the time to read them" and "all staff are to review care plans.

I have three people. They are not good. Care plans are not consistent with the reviews". A member of staff on another unit said "staff write in the daily reports. We try and read care plans and try to do the reviews."

The care plans we looked at were inconsistent, lacked guidance and were not updated following reviews. We found care plans were task led and had little information about people's preferences on how people liked their care to be delivered.

Care plans to support one person living with dementia stated this person had awareness of their condition and staff were to give verbal reminders and to use orientation boards. The action plans lacked detail on when staff were to use verbal reminders. Orientation boards are used to provide information and important reminders such as the staff on duty and activities to take place. The orientation board used on the units had little information about the staff and activities and provided information on the date and the weather.

Care plans were inconsistent. For one person the mobility care plan dated 12 November 2016 stated the person used walking sticks to move around the home. Guidance to staff was given on how to support the person which included ensuring pathways were clear. The review dated 8/5/2017 stated the person had frequent falls and a falls prevention care plan was devised. The falls prevention care plan stated staff were to undertake two hourly checks to ensure this person's safety. However, the mobility care was not updated to reflect recent fall and how staff were to prevent falls.

For another person the care plan stated staff had to reposition the person four hourly but in the review section it said hourly and the person was to elevate their legs. However, the care plan was not updated with this information.

The personal care plan for one person stated they needed assistance with all aspects of personal care and they were to have a shower or bath at least weekly and one to two carers were to support the person". We noted that on 17 May 2017 this person had a "bed bath and 22 May 2017 the staff had assisted the person with "washing and dressing." Daily reports did not provide any confirmation that personal care was consistently delivered. A member of staff said this person no longer had a "bath or shower". This member of staff also said people had to ask to have a bath or shower and five people on the unit would request for showers or baths. They said it was usual for people to have a wash which included "face, hands and bottom half".

A care plan on 'eye care' for one person had not been developed despite staff applying mild shampoo (a known treatment for a specific eye condition) to the eyes four times daily. The "Eye Toilet" chart included the direction on when eye care was to take place and staff were to sign the chart to indicate when eye care had taken place. The personal care plan dated 26 November 2016 stated that "eye bathing four times a day" was needed. The care plan did not include guidance to staff on the eye care to be provided for example was the shampoo to be applied neat or diluted nor the specific shampoo to be used. An agency nurse on duty contacted the GP for further guidance and instructions on the eye care that was to take place. The manager and head of care were not aware that these procedures were being undertaken.

Staff told us handovers on residential units took place when they arrived which gave them up to date information about people. A member of staff said, "Handover sheets are read to staff and hard copies are available for staff to read." Another member of staff said, "Ideally we should know the name of the person and their condition. You need to be aware of the recent things. I would say they could be better. I go into the office and have a look at the care plans myself especially if they are new."

A member of staff on a nursing unit said they "didn't have time to read care plans" but there were handovers

for some staff. They said there was a 10:30 meeting which unit heads were expected to attend but they [nurses] do not always pass it [information] on. Sometimes we are told there is a new admission but we have not been told about things like they need thickeners [for fluids]."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were two full time co-ordinators were responsible for implementing and running the activities programme and were supported by volunteers and care staff. However, the activities co-ordinators were asked to fill in in a variety of support and catering roles to maintain staffing levels. Activities take place every day with coordinators working alternate weekends. Posters and bulletins were on display and informed people of the activities to take place. Activities included one to one time with people and group activities such as coffee/tea socials, arts and crafts, quizzes, trips out to local places of interest, bingo, exercise and music for health flower arranging, indoor gardening and carpet boules.

We saw activities coordinators asking people to join group activities and one to one sessions taking place. Athelstan was marking Dementia awareness week by taking a number of people to Lydiard Park in Swindon.

The comments made by people included "activities are varied - some very good like the various entertainments we have here," "they send over talking books from the library for me – not always my cup of tea but I have enjoyed some that I would never have chosen for myself," "Activities organised. Like the quizzes. We went to the Abbey and sang. That was lovely".

The comments from relatives included "they take mum down to the activities and bring her back when she has had enough," "no singing for the brain." The activities coordinator said "[there] used to be but it stopped" and "when X came in he would just sit, wouldn't come out of his room or join in with any of the activities. We encouraged him to come on a trip to Kemble aerodrome and he agreed. He came with us and had a good time. Now comes to every trip, joins in far more independent. The family can't believe the change in him, so pleased it matters to them".

Staff at Athelstan had been proactive in establishing links with the wider community including providing day care, giving local school pupils the opportunity do work experience or volunteer as part of their Duke of Edinburgh award scheme.

A copy of Athelstan's complaints policy was clearly displayed in the entrance hall. It outlined the stages and the action people were able to if they were not satisfied with the service.

The comments from people included "I don't complain about things but were I to complain I would go to the carers or take it higher up to the bosses". Another person said "I have never complained but I would do if there was something I didn't like," "I would talk to a carer or a nurse if I wasn't happy about things,"

Relatives were aware of the complaints procedure but were concerned that improvements did not take place when they raise concerns. These relatives commented on staff defensive attitude towards their feedback. A relative told us "In November 2016 a group of quite concerned relatives formed a committee to try and get things improved. We hold meetings monthly. Promises made in November 2016 have not happened".

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post. The manager currently overseeing the service was in on a short-term interim position. The head of care had also resigned and was leaving. The staff said in the last 12 months there were five changes of managers. People's comments included "I don't know the manager, it keeps changing" and "I don't know who the manager is". A relative said, "I don't know the manager, a temporary person I think has been brought in." Another relative said, "The management seems more concerned about training than staff." The assistant operations director told us a manager had been appointed and would be going through the CQC registration process in due course.

Fluid intake charts were not consistently completed by the staff. Two staff said that fluid intake was not accurately recorded. They said staff were recording the volume of liquid served into a cup and not amount that the person had actually drank. We noted from the food and fluid charts that staff had not recorded the target intake on the forms or had totalled the intake at the end of the day. This would mean that, where people were at risk of poor hydration, accurately monitoring was not in place and would leave people at higher risk of dehydration.

One person was at high risk of malnutrition with a MUST score of 16 (high). The Eating and Drinking care plan dated 12 November 2016 stated the person had a history of poor appetite and preferred small portions. The care plan included the types of food the person enjoyed, the times when their appetite increased and preference on where to eat meals. The care plan was reviewed on 25 March 2017 and stated the person continued to lose weight, food and fluid charts were to be completed and their weight was to be monitored twice a week. While fluids were taken and alternatives were provided when meals were refused there was no clear indication on the other actions staff had taken. The target amount of fluid in any 24 hours was not recorded and the amount taken as recorded on the fluid chart was not totalled. There was no record of the action taken when the person refused meals and was eating snacks rather than full meals. The lack of monitoring did not provide staff with clear guidance on how to support the person and left them at increased risk of further weight loss.

People told us that staff asked them about the service informally on occasions, but people could not recall completing questionnaires or being asked formally for their feedback. Comments made by people included "they asked us to vote for employee of the month or something like that," "they do not come in to discuss anything like that," "no feedback sought," and " I have never been asked about the place."

A relative told us that a small group of relatives of family members living at Athelstan House proposed 'The Athelstan House Improvement' team meetings to the then interim manager and the head of care. A relative told us "the relatives have a great deal of goodwill towards and appreciation of staff at Athelstan, and suggested that they could see patterns in how things operate that senior staff might find helpful. Also, there were some recurring issues that the relatives hoped could be addressed through mutual discussion". We were told that these meetings were four weekly.

We saw that at the Athelstan House team meetings staffing levels, the quality of the food and communications was discussed. While the minutes of meeting showed there had been some improvements such as the recruitment of staff and the development of menus other concerns had been raised. We saw documented concerns about an agency staff who had already been identified as not working within expected standards was used in another unit despite reassurances that unsuitable agency staff were not going to be used.

Staff told us there was conflict between staff and there was little support from managers. A member of staff said "two staff can't work together. They should be told about their responsibilities". Another member of staff said some staff were more difficult to work with alongside others. Care leaders and unit lead know who these staff are." Another member of staff said "it's more acute on this unit and staff don't like working in the unit." We spoke to the manager and head of care who were aware of conflict between staff. They said new staff were appointed into roles and would be addressing these issues.

A nurse told us they did not lead the team "as much as I would like." The head of care said "I have faith in the carers. Nurses have lost their confidence." The head of care agreed there was a lack of leadership on the nursing units and the RGN's were being helped to delegate with the introduction of allocation sheets."

A member of staff said, "Standards have dropped. Many staff have left. There are a couple of poor carers mostly agency staff and these staff were reported. I was told they would not be used again but the agency worker came back on Thursday". This member of staff also said, "Permanent staff are good. It works when it's all permanent staff".

Following the inspection, the assistant Operations director developed an action plan on the way concerns around management; leadership and communication were to be addressed. We were told the "first employee clinic" was to take place on 6th June 2017 hosted by HR [Human Resources] Advisor. Clinics were then to take place weekly for the next for four weeks and then review thereafter." This meant staff were to be given the opportunity to raise concerns about the leadership of the service to an independent person.

Quality Assurance systems were in place and the standards of care had been assessed against legislation. An action plan on driving improvements was in place. We found areas identified within quality auditing of the home was consistent some of the findings of this inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and were not updated following reviews. Care plans were inconsistent and lacked detail.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessment action plans were not being followed which placed people at greater risk. People wer not repositioned regularly. Food and Fluid charts were not completed by staff and information about people's poor hydration and nutrition was not passed onto to staff coming on duty

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff said people were not safe because they were not able to deliver appropriate levels of care at all time.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Appraisals were not taking place and one to one meetings with a line manager was not taking place. Staff were not able to attend training to develop their skills and to meet

people's needs.

The deployment on staff did not ensure there were sufficient staff on duty to meet people's needs at all times.