The Orders Of St. John Care Trust

OSJCT Athelstan House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Athelstan House is a residential care home providing personal and nursing care to 61 people aged 65 and over at the time of the inspection. The service can support up to 80 people over four units.

People were accommodated in one purpose-built, two-storey home. The four units in the home were referred to as 'households' and were named after different flowers. One unit was accommodating people on a short-term basis. These were people who had been discharged from hospital, for assessment of their care needs. People had access large communal gardens, as well as each household having kitchen/dining rooms and lounges.

People's experience of using this service and what we found
In the two weeks prior to this inspection, two people had left the building without staff support. Measures to improve safety were put in place following these incidents, but the safety shortfalls had not been identified prior to people being able to leave.

People who were accommodated in the dementia care household had been moved upstairs in the home, to the residential households. This decision was made to support hospital discharge processes during the Covid-19 pandemic, with people being discharged from hospital to the home for assessment. Staff, management, and health and social care professionals felt that this had contributed to an increase in physical altercations between people. There were plans to move people again, back to their previous household, in early November 2020.

At the last inspection, we found that people were not consistently being supported to receive food in their required texture. This increased the risk of choking. We found there had been improvements in the management of risks associated with food preparation.

At the last inspection, we also received mixed feedback about the staff availability, and the length of time it took for call-bells to be answered. At this inspection we were told by staff that there had been a recent difficult period and it had been challenging during the Covid-19 pandemic. They referred to being short-staffed and not having the staffing to enable them to do everything that needed to be done. Staff told us there had been recent improvements and we observed there to be enough suitably skilled staff to meet people's needs.

We received mixed feedback from health and social care professionals. These included comments about staffing challenges, as well as difficulty gaining consistent communication with the home. There was also positive feedback about how people were supported to maintain family contact.

Since the last inspection in June 2019, two home managers had left the service. There were temporary arrangements in place for management team at the home while recruitment was ongoing.

People's medicines were managed safely and administered by trained staff. People were supported to make improvements in their health conditions, including their skin and wound care. Their progress was supported and monitored by registered nurses who liaised with health care professionals.

The home was clean and tidy. There were measures in place to reduce the risk of any cross-contamination. Staff wore appropriate personal protective equipment, including masks and when needed, gloves and aprons.

A range of different quality audits took place. Checks of the service were updated to reflect changes in Covid-19 government guidance and when there was learning from accidents or incidents.

People were asked for their feedback to aid improvements and developments at the service. There were also different examples of good community engagement.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 14 August 2019).

Why we inspected
The inspection was prompted in part due to concerns received about how people's safety was supported. A decision was made for us to inspect and examine those risks. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. At this inspection, we undertook a focused inspection to review the key questions of safe and well-led only.
The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Athelstan House on our website at www.cqc.org.uk.

Follow up
We met with the provider following this inspection, to discuss how the service will improve to a good rating. We have requested monthly action plans be provided, so progress at the home can be monitored. We will visit the service earlier than our inspection methodology to ensure the required improvements have been made.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

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

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Athelstan House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. Registered manager's and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We announced our inspection on the day of the visit. This was to ensure we knew how many people had confirmed or suspected Covid-19, and to make sure we had the appropriate personal protective equipment.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report. We reviewed feedback we had received from health and social care professionals about the service. This information was used to help plan our inspection.

During the inspection
We observed people being supported by staff. We spoke with 11 staff members, including the care staff, housekeeping, registered nurses, agency staff, and members of the management team. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care plans for eight people and other documents relating to people's care, such as medicines records and wound charts.

After the inspection
After our visit to the home, we conducted a video call with the area operations manager, peripatetic operations manager, and deputy manager to discuss how the home was led. We reviewed records relating to the management of the home. We also sought feedback from health and social care professionals. Five professionals shared feedback with us by phone call and email.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

- People were not always protected against risks associated with the security of the property. Two people had been able to leave due to the property not being kept secure. Although the two people did not come to any harm, there was an increased risk that harm could have occurred.
- Following these incidents, thorough investigations took place. There was good collaborative work sharing information with the safeguarding and commissioning teams at the local authority. De-briefs and reflective practice took place with staff, following incidents. These discussions were to identify what happened and where improvements could be made.
- Preventative and supportive action could have been taken quicker, following one person leaving the home. The person's records did not reflect how their wellbeing was monitored. Observation charts were not put in place until five hours after the person returned. We advised the management team of our findings.
- Action was taken to improve the security and safety of the property, where people had been able to leave. These actions were to implement good practice safe care measures, which were not pro-actively in place prior to the incidents taking place. These included, ensuring external contractors secured garden gates, completing "head-counts" throughout the day and night. Also, ensuring suitable alarm systems in place and where required, were manually activated. These actions had been included in the home's ongoing action plan. The management team understood these actions needed to become embedded into every day safe practice and were monitoring this.
- There had also been incidents of altercations between people who had been moved from the dementia care household, to a residential household. This was to accommodate people who were being discharged from hospital during the Covid-19 pandemic and were awaiting further assessment. The move was made in consultation with the local authority and was deemed to be a suitable decision in people's best interests. The management team and professionals were in agreement that these incidents may not have happened if people had not been moved. Measures needed to monitor risks and prevent harm were put in place. There were plans to revert back to having the dementia household, by early November 2020.
- Other risks to people's safety were identified and assessed. These included risks of choking, falling, and people's needs during an emergency evacuation of the building. Measures were recorded for staff to follow, to reduce the likelihood of harm occurring. These were detailed and cross-referenced to care plans, where staff could see further information about supporting the person.

Staffing and recruitment

- There were enough suitably skilled staff available to meet people's needs. Call bells were responded to promptly. Staff worked well together, and there was evidence of staff using their clinical knowledge to support improvements in people's health care conditions.

● Prior to and after the inspection, we received mixed feedback from health and social care professionals about the staff skills mix. Staff feedback supported what the professionals told us. Staff we spoke with told us they felt there had been improvements in the recent weeks prior to the inspection. One staff member said, "We did have a really difficult time recently. We just didn't stop. There wasn't enough time or enough staff to do what we needed to do. It has got better now. We have more staff and things feel better."
● We observed the agency care staff on shift during our inspection. One agency staff member told us they were working their second shift at the home. They confirmed with us that they felt they had been given the information and induction they needed to meet people's needs. We observed other agency staff who knew people well and informed us they had worked regular shifts at the home.
● At the last inspection, we had no concerns about the recruitment processes for new staff. The provider had thorough safe recruitment processes in place, including ensuring background and character checks took place. These included checks with the disclosure and barring service (DBS). The DBS help employers to make safer recruitment decisions, by preventing unsuitable people from working with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
● There were systems in place to safely support people and protect them from the risk of abuse.
● People were supported by staff who received safeguarding training. Staff knew how to raise concerns at the home. They also knew they could speak out about poor practice by whistle-blowing to CQC.
● The management team knew when to submit notifications to CQC and the local authority, notifying of any safeguarding concerns or incidents.

Using medicines safely
● People were supported to receive their medicines safely and as per the prescriber's instructions. Medicines were administered by trained staff who had their competencies checked.
● Regular checks and audits of the medicines took place. Medicines were stored safely. We found no errors or gaps in the medicine administration records.
● People who required medicines on an 'as and when required' (PRN) basis, had protocols in place to ensure they received the right support to meet their needs. The PRN protocols directed staff as to when the medicines should be given, and any additional support people may need.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections. There were measures in place upon arrival to the home, including ensuring visitors sanitised their hands, and used the correct personal protective equipment (PPE).
● We were assured that the provider was meeting shielding and social distancing rules. During our inspection, one person had been confirmed as having Covid-19. We were advised where the person was, and we saw staff working appropriately to support them.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely. We saw PPE stations throughout the home, these included gloves, aprons, antibacterial wipes, and staff were all wearing masks.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Risks of cross-contamination were reduced with staff working on set floors of the home, and hand-hygiene stations at the entrance to each household.
● We were assured that the provider was making sure infection outbreaks can be effectively managed. The local authority reported recent improvements in how communication with the home about Covid-19 had improved in the weeks following our site visit.
● We were assured that the provider's infection prevention and control policy was up to date. Updates had

been added to the policy throughout the Covid-19 pandemic.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The home did not have a registered manager in post at the time of this inspection. The provider was actively recruiting for a new manager.
- Two managers had left the service in the 14 months since the last inspection. There were no formal records obtained by the provider or exit interviews to identify whether there were any key themes contributing to this level of management turnover. Exit interviews were done as an anonymous and optional paper-based questionnaire for managers leaving the provider's homes.
- Plans were in place for the leadership of the home while a new home manager was recruited. These included a management team of a home manager from another service, a peripatetic operations manager, an operations manager, and the home's deputy manager. The management team understood their regulatory requirements.
- We were advised after the inspection that a temporary nursing manager had been appointed. Their role was to oversee the home and its clinical governance on an interim basis.
- There were areas of quality monitoring in the home that could be improved, to ensure consistency in each household. We found records in one household to monitor people's fluid and food intake were of variable quality. However, in the household opposite, these were much more consistent. This was the same for the daily records, where staff documented what people had been supported to do and any observations about their wellbeing.
- A range of different quality monitoring audits were in place. These were completed by different members of the management team. There were also provider quality audits, which showed good compliance with the provider's quality standards.
- Staff were clear about their roles and felt they received the right support from the management team to meet people's needs. Regular meetings took place during the day. These included twice daily clinical meetings, and an afternoon handover meeting to ensure all staff knew of any important updates about each person. Night staff were met with throughout the week. One staff member told us, "I think the team here are really good. We all care about and support one another."
- The provider held regular 'Requires Improvement to Good' meetings, following the last inspection. The management team had an ongoing home improvement plan, which included findings from any incidents and reflective practice.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people
● Managers and staff promoted a person-centred culture at the service. We overheard and observed kind and caring interactions when people were supported by staff.
● People's care needs were documented in person-centred care plans, which were regularly reviewed and updated when people's needs changed. Staff could access information in these about what people liked to do, their hobbies and interests, as well as their care information.
● At the last inspection we found no concerns regarding how caring the service people received was. Information received since the last inspection related mostly to the challenges of supporting people during the Covid-19 pandemic. We found that adaptations had been made to the type of activities and social engagement opportunities people had, to ensure safe social distancing.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were many positive examples of how people had been supported to engage with the local community prior to and during the Covid-19 pandemic. These included creative work with the local museum, to produce a piece of textile art celebrating the community. Also, taking part in the local 'in bloom' competition. During the pandemic, one member of the community had made and sold face coverings, to raise money to provide the home with interactive electronic speakers.
● We received positive feedback from professionals about how people had been supported to maintain contact with their relatives. One professional said, "they have gone above and beyond to make sure [Person's] husband can see her." Other professionals commented on the positive feedback they had received from people's family members about the person-centred care.
● The management team explained the staff team had helped to facilitate video calls, phone calls, and socially distanced garden visits. People also made cards to send to their relatives and the home had a social media page they encouraged relatives to follow to see updates.
● Staff had been praised by the provider and management team for their work and ongoing efforts in supporting people during the Covid-19 pandemic. This included vouchers and other incentives.
● A commemorative service had been held to remember those who had passed away during the pandemic. Additional support was put in place for staff, focussing on their wellbeing.
● People were encouraged to share their feedback about the service. This included, 'food for thought' meetings with the chef. The management team reported changes in the menu's, following feedback from people at our last inspection. These included more vegetarian and plant-based options.

Working in partnership with others; continuous learning and improving care
● Improvements had been made to different aspects of people's care since the last inspection, despite the challenging circumstances of the Covid-19 pandemic. Clinical care plans for people's specific health care needs were in place and there was improved clinical governance.
● There were examples of learning taking place following incidents. These included more checks on fire doors and ensuring each person was present. There was a reflective practice log in place, containing records of what had happened and what had been reflected upon or changed as an outcome of this.
● Reflective practice also took place reviewing any historic complaints, to ensure all areas for learning had been captured and acted upon.
● The home was supported by the provider's admiral nurse. An admiral nurse is a dementia and mental health specialist nurse. Their supportive work included working with staff around specific challenges in meeting people's needs; ensuring staff had the resources and knowledge.
● We received feedback from different health and social care professionals that communication with the home was not always consistent and had at times been challenging.
● However, there were good examples of working partnerships with health and social care professionals.

These included a nutritional support service, with a named nutrition nurse. This nurse was working with the home to focus on post-Covid-19 nutrition, for people who had recovered from the virus.

● Ways of working had changed during the Covid-19 pandemic. These included online staff training, completed via video call. Also, providing mental health and bereavement support services/resources to people's relatives and staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The management team understood their responsibilities to inform people and their relatives if something went wrong. They investigated and reported back to people and their relatives, including information about any actions taken to stop things going wrong again. One member of the management team said, "We are completely open and transparent with people's relatives."