Autumn House Care Limited

# Autumn House Residential Home

## Inspection report

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11 July 2018

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection took place on 9 and 11 July 2018 and was unannounced.

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

Autumn House is registered to provide accommodation for up to 44 people, including people living with dementia care needs. At the time of our inspection, there were 35 people living at the service. The service was arranged over three floors connected by staircases and one lift. Accommodation was arranged over the ground and second floors, and the third floor was used as an area for staff and management only. All bedrooms had en-suite facilities and there were three communal bathrooms positioned on the ground and first floors. There were three lounges, two dining rooms and a garden area that people could easily access.

There was a registered manager at the service. 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.

The last inspection of this service was in December 2015, when the service was rated Good overall. At this inspection, we found the service was not meeting legal requirements and was rated Requires Improvement.

There were quality assurance systems in place based on a range of audits. However, we found these were not always effective and had not identified the concerns raised during the inspection.

The service used a computerised care system for people's care plans and associated records, however this was not always clear and did not provide the registered manager with a robust oversight of how people's needs were being managed.

People's care plans contained individual information, however some areas did not always reflect people's needs consistently. Risks to people were not always managed effectively to ensure they were minimised.

Although staff told us they felt supported in their role, we identified that training was not always up to date.

Staff who administered medicines had received training and had their competency to administer medicines assessed to ensure their practice was safe. However, we identified medicines were not always stored safely.

The provider and registered manager had an understanding around their responsibilities of protecting people's rights in line with the Mental Capacity Act 2005; however, this was not always recorded and best interest decisions had not been completed appropriately. Action had not always been taken to ensure that

decisions were legally made on people's behalf.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people from abuse.

There were enough staff to meet people's needs in a timely way. Appropriate recruitment procedures were in place and pre-employment checks were completed before staff started working with people.

People's dietary needs were met and they received appropriate support to eat and drink enough. Adaptations and improvements had been made to the home to make it supportive of the people living there.

People were supported to access healthcare services when needed. Staff made information available to other healthcare providers to help ensure continuity of care and supported communication between people and health professionals.

People were cared for with kindness and compassion. Staff knew people well and built positive relationships with them. They were skilled at engaging with people to effectively meet people's communication needs.

Staff protected people's privacy and dignity. They encouraged people to remain as independent as possible and involved them in planning the care and support they received.

People had access to a range of activities based on their individual interests, including regular access to the community. They knew how to make a complaint and an accessible complaints procedure was in place.

Visitors and professionals who had regular contact with the home felt it was run well. Staff were organised, motivated and worked well as a team. They enjoyed working at the home and told us they felt valued.

There was an open culture where people were consulted and staff enjoyed positive working relationships with health and social care professionals.

## 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.

Risks to people were not always managed effectively to ensure they were minimised.

Medicines were not always stored safely.

People said they felt safe and staff understood their safeguarding responsibilities.

There were sufficient staff to meet people's needs and appropriate recruitment procedures were in place.

There were systems in place to protect people from the risk of infection and environmental risks were managed effectively.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff received a variety of relevant training, however this was not always updated in line with the provider's procedures.

Action was not always taken to ensure decisions were legally made on people's behalf. The views of relevant people were not always recorded when decisions were made in people's best interests.

People were supported to access healthcare services when they required them.

People had enough to eat and drink and were offered a choice at meal times.

The environment was supportive of people who lived there and people were involved in decisions around the decoration of the service.

### Is the service caring?

**Good**

The service was caring.

Staff treated people with kindness and compassion. We observed positive and supportive interactions between people and staff.

People and their property were treated with dignity and respect.

Staff knew how to communicate with people on an individual basis depending on their needs.

Staff encouraged people to be independent and knew how to protect people's privacy.

## Is the service responsive?

**Good**

The service was responsive.

Care plans contained information to support staff to provide care in a personalised way.

Care and support was planned in partnership with people, their families and healthcare professionals where appropriate.

People received appropriate mental and physical stimulation and had access to activities they enjoyed.

The provider had arrangements in place to deal with complaints.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

A quality assurance process was in place; however, this had not identified all the areas of concerns we found during this inspection.

People and their relatives felt the service was good, and were regularly asked about their views of the service.

There was an open culture and staff told us they felt supported by the registered manager and provider.

The service had developed links with the community and the registered manager kept up to date with relevant announcements and alerts.

The policies and procedures we looked at during the inspection were appropriate for the type of service.

# Autumn House Residential Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 9 and 11 July 2018 and was unannounced. On the first day of the inspection there were two inspectors and an expert by experience in dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection, there was one inspector.

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

We spoke with 10 people living at Autumn House, four relatives and four visiting health professionals. We also spoke with the provider, the registered manager, the deputy manager, five care staff, an activities co-ordinator, two kitchen staff and one domestic assistant. We looked at care plans and associated records for six people, staff duty records, staff recruitment files for four staff, policies and procedures and quality assurance records. We also spent time observing the care and support people received in communal areas of the service. 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.

The last comprehensive inspection of this service was in December 2015 when we did not identify any breaches of regulation.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe at Autumn House and their visitors confirmed that they felt people were safe. One relative told us, "Nothing is too much trouble and I know [my family member] is safe and being looked after." Staff had received safeguarding training and knew how to identify, prevent and report abuse. One staff member said, "If I had any concerns I would go to [the registered manager], they would do something straight away." Staff were confident that the registered manager would respond to any concerns they raised. Staff had access to phone numbers for the local authority safeguarding team and were aware of how to contact them should the need arise. Records confirmed that the registered manager had reported incidents appropriately and promptly to the local safeguarding authority and taken action when required to keep people safe.

We looked at people's care files, which showed individual risks to people had been assessed. However, we identified that risks to people had not always been fully explored to ensure that the risks were minimised and people's associated care records were updated. For example, one person who was receiving a blood thinning medicine did not have any guidance or risk assessment within their care plan regarding the high risk of bleeding that may occur if the person was injured. Another person's care plan contained a hospital discharge letter which stated their allergies; however, this had not been updated within their care plan, or on their Medicine Administration Record (MAR). We raised this with the registered manager who told us they had not reviewed the discharge letter to be aware of the person's allergies. On the second day of the inspection, the deputy manager had taken action to ensure the person's records were updated with this information. The failure to note these allergies meant risks relating to this had not been assessed or managed.

Environmental risk assessments had been completed appropriately to ensure each risk identified was managed effectively, including information about who is at risk and who is responsible for controlling the risk. Gas and electrical appliances were serviced routinely. Fire safety systems were checked and audited regularly and staff were clear about what to do in the event of a fire. We saw records of recent fire drills that had taken place and staff had been trained to administer first aid. In addition, each person had a personal emergency evacuation plan (PEEP), detailing the individual support they would need if the building had to be evacuated.

Medicines were secure at all times, but were not always stored at a safe temperature. Staff were recording the temperature of the medicines storage fridge in the morning and afternoon. On nine of the fourteen days preceding the inspection, recordings showed that the fridge had been at one degree Celsius. We checked the medicine stored in the fridge and this stated it should not be stored below two degrees. Other medicines were kept securely in two medicines trolleys. Temperature recordings for these also showed that on occasions the temperature had exceeded the maximum safe storage temperature of 25 degrees Celsius. As a result of our intervention, the registered manager contacted a pharmacist to confirm whether the medicines were safe to use. Prescribed topical creams should only be used for the named person they have been prescribed for, they should be stored within certain temperatures and replaced when they have been opened for longer than specified as safe by the manufacturer. We identified that the service was not

operating an effective system to help ensure topical creams were not used beyond the manufacturers' 'use-by' dates.

We discussed the above issues with service managers and by the second day of the inspection, action had been taken to ensure all medicines were being stored and managed safely.

Staff administering medicines had received appropriate training and their competency was assessed prior to their administering medicines and on a regular basis. Several people were prescribed 'as required' (PRN) medicine for agitation, pain or constipation. Specific guidance was available for care staff including when the medicine should be administered, possible side effects and any special instructions relevant to the person. The effects of administration had been recorded which meant that when required, prescribers would be able to review medicines accurately and effectively.

There were appropriate systems in place to protect people by the prevention and control of infection. Staff had attended infection control training and confirmed they had access to personal protective equipment (PPE) which we saw they used when needed. A domestic assistant described how they processed soiled linen using special bags that could be put straight into the washing machine. We saw this process was followed and systems within the laundry room were well organised to keep clean and dirty laundry separate. All areas of the home were clean and cleaning schedules were in place to help ensure cleaning was done consistently, using appropriate products. Systems and checks were in place to ensure people were protected from the risks associated with water borne infections, such as Legionella. The registered manager was able to describe the actions they would take should there be an infectious outbreak at the home and infection control audits were undertaken at regular intervals as part of an overall quality monitoring process. The home had been awarded five stars (the maximum rating available), for food hygiene by the local environmental health department.

Potential new staff were shown around the home and introduced to some of the people using the service as part of the interview process. The registered manager told us that where possible, feedback was sought from people living at the home, to give their initial views of the potential new staff member. Appropriate arrangements were in place to ensure that staff were suitable to be employed at the service. Staff recruitment records for four members of staff showed that the manager had operated thorough recruitment checks in line with their policies and procedures to keep people safe. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which would identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff files included application forms, references and health declarations. There was a formal approach to interviews with records kept demonstrating why applicants had been employed.

There were enough staff deployed to meet people's needs. One relative said, "The staff always respond quickly when [the person] uses the bell." The registered manager told us that staffing levels were assessed and reviewed according to people's level of support required and the service used a delegation schedule to identify and inform staff of their responsibilities and set tasks for each shift. Staff told us this worked well, and they felt staffing levels were sufficient for the amount of people living at the service and their needs. Staff comments included, "We have the delegation sheets. We do really well, we always know who is doing what" and, "Yes, [staffing levels] are about right. We are never rushed."

Requires Improvement

# Is the service effective?

## Our findings

Staff received an induction into their role and worked alongside more experienced staff when they first started employment. Where new staff did not have any prior relevant experience or qualifications, they would undertake the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

Staff received a variety of training courses which were delivered via online 'e-learning' sessions, in addition to practical classroom sessions for areas such as moving and handling and first aid. Staff told us they found training 'useful' and 'interesting'. Their comments included, "[e-learning] is good, we can even do it at home too" and, "We do distance courses, they let us do as many as we want." The service used a training matrix to help identify where training was due for each member of staff according to a certain period of time. However, we found that this was not being followed, as some staff had gone beyond their refresher date for training in one or more areas. We discussed this with the deputy manager who confirmed they were aware that not all training was up to date and agreed for this to be followed up with individual staff members.

Staff were supported appropriately and felt valued. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns and discuss training needs. Supervision records viewed were brief and the registered manager told us that supervisions sessions were often based on an informal format. Despite the lack of extensive records, staff told us they felt supported in their role and were able to raise a concern at any time, alongside regular 'catch up' sessions with the registered manager or another senior staff member.

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 decision made on their behalf must be in their best interests and as least restrictive as possible. Although the registered manager was aware of their responsibilities in line with the MCA, we identified that people's records did not always show how decisions about their care and treatment had been made, or who had been consulted. For example, one person was receiving all personal care in their bedroom in a profile bed, with bed rails in place. The registered manager advised that a relevant best interest decision meeting had been held with the person's family and health professionals, but we could not identify a record of this being completed. By the second day of the inspection, the registered manager had taken action to ensure that this was recorded in the person's care plan.

For day to day decisions and personal care, people's consent and preferences were considered by staff. For example, we heard a staff member asking where they wanted to sit at lunch time and offered them choice throughout the meal. People were not rushed to make a decision and staff took time to let people communicate what they wanted. However, where people's care plans stated they had a Lasting Power of Attorney (LPoA) in place, the registered manager was unable to confirm that copies of this had been seen and verified. A LPoA is a person who is legally appointed to make decisions on a person's behalf where they lacked capacity to do so. This meant that they could not be assured that decisions were legally being made

on people's behalf. On the second day of the inspection, the registered manager had taken action to request copies of these documents.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements and DoLS applications had been made to the supervisory body where relevant.

People were supported to maintain good health and had access to appropriate healthcare services when required. One relative said, "The medical attention here is excellent. The staff are well trained, and [the person] is treated with dignity and respect. He can see any healthcare specialist any time I want for him". People's records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. For example, we saw that where concerns had been identified with a person's skin viability, a chronological record was documented to show the involvement of relevant health professionals and prescriptions given. All healthcare professionals we spoke with felt that people's healthcare needs were being met and confirmed that the service made contact with them appropriately to ensure that new and existing needs were managed effectively.

Staff were kept up to date about people's needs through written handover notes and verbal handover meetings, which were held at the start of every shift. Information provided to staff included details about people's emotional and physical health needs and meant that staff worked together to ensure that people's on-going needs were met. One staff member said, "We get a handover and we read through the diary in case anything is missed. [The deputy manager] will always inform us of anything we need to know, or put it on the staff board." Throughout the inspection, we noted that staff worked co-operatively together for the benefit of people and were attentive to ensuring that people's needs were addressed. For example, we overheard one staff member saying to another at the start of their shift, "Is there anything else I need to know from handover, has anything else happened?"

People's needs were met by the adaptation, design and decoration of premises. Autumn House is an older style building, consisting of several joined houses. Each area of the home was decorated with a theme and colour, to help people differentiate which area of the home they were in and where their bedroom could be found. For example, one area of the home was named 'Movie Mile' with posters of old films hung along the corridor. The registered manager told us that people had been included in deciding which film posters to display, and staff often used them as conversation starters to stimulate people living with dementia. Bedroom doors were decorated to tie in with the theme of that area of the home, and had a picture of the person on the front to make it easier for people to find their own rooms. There were also large signs in place throughout the home to help people navigate their way around the building. In addition to people's bedrooms and communal areas, the service also had designed rooms for people to receive treatments, such as a massage room, a consultation room and a hairdressing salon. The registered manager told us, "It's important for people to feel as though they are having an appointment, as they would living in the community." People were able to choose where they spent their time and there were a number of communal areas available to people, including dining areas, lounges and an enclosed garden which had seating and tables available to people.

People were supported to have enough to eat and drink. Drinks and snacks were offered throughout the day and evening. People and their families were complimentary about the food. One person said, "The food is very good, we get a choice for breakfast and main course each day, we can also have something different if

we like." People were provided with a choice of food at mealtimes and alternatives were offered if they did not want what was on the menu. We spoke with the chef who confirmed they were flexible with the menu choices and were happy to visit a nearby shop if there was something in particular that a person requested. When new people moved to the service, their dietary needs were explored by management and this was passed to catering staff accordingly. We noted that where people required their meals in a softer format due to the risk of choking, this was provided. Staff were attentive to people during mealtimes and provided support where required. On the first day of the inspection, we observed people having lunch in the communal dining room and noted staff were considerate and patient with people whilst they were eating. Staff checked with people if they had finished before removing their plate and did not rush people to finish their main course once they had begun serving dessert. People were able to choose to eat in a dining room, lounge or their bedroom according to their personal preference or needs.

The service used technology to record people's care records and observations electronically via a computerised system. The system sent alerts to the registered manager to review people's care records; however, we identified that this was not always managed effectively to provide assurance that people's needs were being met. You can see more information about our findings in this area in the 'Well-led' section of the report. The registered manager told us about how technology was being used to stay in touch with people's relatives and provide a communication link. For example, one person had a relative who lived abroad and the service kept in contact with them via social media to send instant messages and pictures of their loved one at Autumn House.

Good

# Is the service caring?

## Our findings

People were supported by kind, caring and compassionate staff. People spoke positively about the staff and told us they were looked after well. A relative of a person living at the service told us, "The staff are unfailingly kind, and I am impressed with them. There is an atmosphere of good humour combined with politeness." Another said, "The staff are exceptional. They are so kind and they have a thorough understanding of my [relative's] needs". We spoke with visiting health professionals who also described staff as caring and friendly. They confirmed staff always attended appointments with people where necessary and took the time to ensure that people were aware of when appointments were scheduled, such as a blood test.

People were cared for with dignity and respect. Without exception, all interactions we observed between people and staff were positive and supportive. Staff spoke with people in a polite and engaging manner and took time to engage with people on a personal level. For example, we observed a staff member enter a communal area of the service where people were sat talking. The staff member addressed people individually and politely, asking if they would like a copy of the daily newsletter. Where people wanted to read the newsletter, the staff member identified if they required support, and sat with them to read through what was written, prompting conversation about their interests and memories. On another occasion when a person told a staff member they were cold, the staff member replied, "Would you like me to get you a cardigan? Which colour one would you like?" This showed consideration for the person's choice. Staff took care to look after people's property and keep their rooms tidy, for example, people's clothes were hung neatly in wardrobes.

'Thank you' cards sent to staff by family members, and reviews of the service completed by relatives included the following comments: "I am so happy [my relative] is where she is, cared for with love and dedication", "My [relative] came to Autumn House a few weeks ago, we cannot be more pleased with the care and kindness he is given, the staff are fantastic" and, "I found the organisation and welcoming procedure 5 stars, the staff and management were extremely helpful and very kind during this difficult time, and settled my [relative] in with no fuss at all."

Staff were skilled in understanding people's communication needs and acted considerately towards people living with dementia. For example, we observed one person asked a care staff member if they knew where their mum was. The staff member told the person, "Oh, I think they have just popped out, do you want to come with me?" The interaction showed that staff knew how to respond to a person living with dementia who was demonstrating a verbal anxiety by wanting a familiar, safe person. The staff member acted appropriately to support the person and made them feel reassured.

People's privacy was respected when they were supported with personal care. During the inspection we observed staff knocking on doors, and asking people's permission before entering their bedrooms. Where people were cared for in bed, the service used a system of putting a picture of a daffodil on their bedroom door, so that all staff, including domestic and maintenance staff, were able to discreetly recognise people's needs. Staff were able to describe the practical steps they took to preserve people's dignity and privacy

when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered when providing personal care.

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

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. One person told us, "I do have a call button so I don't ever feel isolated, I think they [staff] go out of their way to encourage us to feel independent". A staff member told us, "If I help [a named person] with personal care, I will give them a flannel so they can wash some areas for themselves." People's care plans contained guidance for staff which was reflective of the emphasis to ensure people remained as independent as possible with the skills they had. One person's care plan stated, '[The person] uses a zimmer frame when mobilising. When moving around the home with her, staff need to remind her not to push her frame too far forward without moving her feet.'

People and relatives told us they were involved in discussing and making decisions about the care and support they received. A family member told us, "I believe [my relative] is genuinely happy here, I am even invited to discussions with the care team who look after her." The registered manager was aware of how to request the services of independent advocates if needed. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want. Care records confirmed that advocates had previously been used to support people and the registered manager knew where and when to contact them.

The registered manager told us they explored people's cultural and diversity needs during pre-admission assessments and included people's specific needs in their care plans. This included people's faith needs and whether they preferred male or female care staff to support them with personal care. Further information was included in a life history document which the activities co-ordinator completed once the person had settled in to the home. Staff were considerate of all people's diversity needs and supported people to follow their faith. For example, where a person living at the service was of a faith that did not celebrate Christmas, staff had considered the person's cultural preferences when putting up Christmas decorations around the premises and offered an alternative meal to a Christmas Lunch. In another instance, the registered manager spoke with us about a person who came to Autumn House in the past who was transgender. The registered manager told us staff were offered support to ensure that the person's needs were met without discrimination. The service had also made links with a local Church and a minister visited regularly to give Holy Communion to people who wished to receive it.

Good

# Is the service responsive?

## Our findings

The service was responsive to people's needs. Staff provided flexible and individual care and support to people. A family member told us, "[My relative] likes to have a 'tot' of brandy and a packet of cheese and onion crisps every night. They found this out without me asking, and simply arranged it. Now it happens every day. That is what I call good service".

Care and support was planned in partnership with the people using the service, their family members and healthcare professionals where appropriate. Assessments were completed before each person moved into the home to ensure their needs could be appropriately met. Reviews of care plans took place regularly and people were supported by an allocated key worker to review their care plans. Relatives told us that they were fully involved in the development and reviews of care plans and kept up to date about changes in their loved ones' wellbeing. A family member said, "I visit my [relative] here every day, and I know exactly what is going on. I can get anything done for her she could want".

Each person's care plan contained individual information about their needs and how they wished them to be met. However, we identified some inconsistencies around specific decisions of people's care and how this was recorded within their care plan. For example, we identified that recordings in different areas of people's care plans were often unclear and conflicting. For example, one area of a person's care plan stated they were able to mobilise unaided around the building, whilst another section stated the person required staff to walk with them at all times to avoid bumping into things, despite the fact that the person was now being cared for in bed.

The risks posed by inaccurate information in the care plans were mitigated by the relatively low turnover of staff and the fact that staff knew people well. When we spoke with staff they all demonstrated an extensive knowledge of people, including their current needs, wishes and preferences. We also identified evidence in other sections of people's care plans of person-centred information about their needs, routines and how they should be supported. For example, one person's care plan said, '[Person's name] enjoys a normal diet. She is able to eat and drink independently, she uses the pink dining room for her meals, she can be quite slow at eating.' Another said, '[Person's name] requires staff to support her with person care, using the toilet and engaging in activities. [Person's name] enjoys sensory activities, and catching games, they will participate in quizzes, they also enjoy listening to Radio 2.' Care plans contained clear guidance for staff on how to use distraction techniques for certain people, before needing to administer medicine to reduce people's anxiety. For example, guidelines for one person stated, 'Take [person's name] to a quiet place. Offer them a drink. Engage in conversation.'

People were provided with a wide range of activities to ensure appropriate mental and physical stimulation. There was an activities co-ordinator employed by the service, who was responsible for organising activities, events and chairing resident meetings. There was a weekly timetable of activities on display in a communal area of the service and this included activities such as games, music, baking, pet therapy and chair exercises. A relative told us, "The staff are proactive, always cheerful and happy go lucky. [Person's name] always enjoys the activities, he is always kept occupied." The activities co-ordinator had recently implemented a

system to determine people's level of engagement with different types of stimulation and identify how they interacted best. This ensured that people were supported by staff to participate in activities in line with their abilities and preferences. In addition to weekly group activities, the service had individually explored people's past history, interests and cultural needs by talking to people, their relatives and getting know them and their backgrounds. For example, the registered manager spoke with us about one person who had always supported a local football team. The person's keyworker had contacted the team, and they offered for the person to visit the team grounds as well as sending posters and football programs. The service used an 'individual activity profile' to record this information in detail and documented pictures and written records of activities that people had been involved in.

The service had a focus on and promoted people's wellbeing. For example, people were able to receive a full massage service from an in-house masseuse, in the comfort of their bedroom, a communal lounge or a private therapy room. The service had also introduced a holistic relaxation therapy called 'Namaste', which took place twice a day in a communal lounge area. The sessions were designed to provide a period of sensory relaxation and mediation for people, including those living with dementia. We spoke with staff about the 'Namaste' therapy, who described the success of the sessions and the benefit this had for people, particularly those who tended to internalise any worries or anxieties. We also saw feedback that had been received from a social care professional acknowledging the therapy sessions as 'exemplary'.

The service had worked hard to organise and hold regular 'theme days' throughout the year. The registered manager told us about their plans for the next '1940's' theme day, which included staff dressing up, decorating the building and inviting a 1940s singer. We looked at pictures of past theme days, such as a 'Circus Day', 'Tropical Day' and a 'Christmas Winter Wonderland', which the registered manager commented Autumn House was 'famous' for in the community. All staff spoken with were positive about the theme days and told us how important they were for the people living at the service and their loved ones. One staff member said, "The theme days are really fun, the residents love them and families come in too, it brings us all together."

The service held regular resident meetings and we saw records of meetings which discussed upcoming events and changes within the service, such as a new staff therapist and building works due to take place. Where people had made comments and suggestions, action had been documented on an 'outcomes' sheet to clarify proposed follow up actions. For example, changes in menu choices and planned activities for the next 'theme day'.

At the time of the inspection, no one living at Autumn House was receiving end of life care. Staff had received training in end of life care from the local hospice and demonstrated they understood this; however, we identified there was a lack of consistent information available in people's care record regarding their end of life wishes. We discussed this with the registered manager who agreed that the current information held for people's end of life care preferences was limited and that they had faced challenges in trying to obtain information from people's relatives. By the second day of the inspection, the registered manager had designed a template to be used to capture key information regarding people's end of life wishes such as; music preferences, who they wished to be present and any religious considerations.

The service had arrangements in place to deal with complaints and people told us they felt able to raise concerns. A family member said, "I don't have any problem raising a complaint, I have only had to do it on one occasion", "I spoke to the manager about the matter concerned, it was in connection with another resident and action was taken without any delay. If you raise a complaint here I guarantee action will be taken." The registered manager discussed how key workers supported people to talk about any concerns they had, in order to resolve them effectively. Where people were living with dementia, staff were able to

recognise changes in people's behaviour or expression, which may suggest an issue or a concern. We viewed records of recent complaints. These had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. The registered manager described how they used complaints to help identify learning and to improve the service.

Requires Improvement

# Is the service well-led?

## Our findings

People told us they were happy living at Autumn House and felt the service was well-led. One person said, "This is a well-managed home." Another said, "I could not ask for anything better." A family member told us, "I am delighted with the care [my family member] receives here. I think the staff here are marvellous and the manager is doing a great job. This place is wonderful". Without exception, all staff and health professionals we spoke with told us they would recommend the service and would be happy for a family member to live there.

Quality assurance systems had been developed to assess, monitor and improve the service, but were not always effective. Audits carried out by the provider and registered manager had not identified the areas of improvement we found during our inspection. These related to: staff training, the management of medicines, the recording of MCA assessments and best interest decisions, and conflicting information in people's care plans. The service used a computerised system to record all care observations and to create care planning documents for people living at Autumn House. We reviewed records for people and identified the processes for documenting people's care was not always robust. For example, we looked at daily observation records for one person which stated they were reviewed by the registered manager on a certain date. When we discussed this with the registered manager, we found that it was not always clear as to which member of staff had inputted information and on which date. This meant that in the event of an investigation, reports produced by the system could not be relied upon for the purpose of an audit trail. The issues we identified regarding how information was recorded in people's care records demonstrated that further time was needed to develop and fully embed the quality assurance systems in practice.

There was a clear management structure in place consisting of the registered manager, deputy manager, head of care and senior care staff. Each had clear roles and responsibilities and the management team worked well together. Staff told us they felt the registered manager was 'approachable' and 'very supportive'. Comments included, "[The registered manager] is very easy to approach, very understanding, she is so easy to talk too" and, "If I ever have something to bring up, they [management] are there."

The registered manager told us they felt supported by the provider, who visited regularly. They said, 'We are really lucky to have our directors 100% behind us and supporting our ideas. We all want to take the home to the next level, we all come from the same page." Staff also confirmed they felt the provider was visible and supportive. They commented, "[The provider] pops in quite a lot. They will say, 'If you have any worries, just ring me.' She's very good, she always shows concern."

Staff told us they enjoyed working at the home and found the staff team supportive. One staff member said, "I love it, everybody is like a family, we have a laugh. If you have a worry, there is always someone to chat to about it." Another said, "All the girls are so friendly and caring, that's why I enjoy working here." We observed a positive, open culture throughout the inspection and saw that staff spoke to each other and the registered manager with kindness and respect.

The registered manager told us the values of the service were based on delivering the 'best possible care to

people' whilst 'ensuring they feel safe and valued.' They said, "If anyone comes in, we are there for them, their family and friends included" and, "We try to cover all aspects of dementia and do something for everyone. We don't want people to just get up in the morning, sit in the lounge and go back to bed. We want to be able to help people to do everything they want."

People were consulted in a range of ways about the way the service was run, such as through regular 'resident meetings' and individual discussions with people and their relatives. The registered manager told us about one family member who had recently been reconnected with their loved one and was keen to start a family support group. During the inspection, we spoke with the family member, who told us, "I am confident that if I raised any suggestion it would be welcome. There is an atmosphere of 'can do', that starts from the top. We as a particular group of relatives representing our family members are so impressed with the way this place is run that we are starting a help group to show our support and appreciation". In addition, we saw a comments box had been installed in the hallway to enable people to provide feedback anonymously if they wished, including staff members. The registered manager told us they were open to suggestions from people, staff and all visitors to the service and commented, "We are constantly looking at ways to improve, we want to be the best."

The provider had a business continuity plan which contained clear detail regarding the action to be taken in the event of specific incidents, such as a power supply outage. The service had subscriptions to a variety of relevant resources in order to stay up to date with important announcements, public health messages, information and guidance. The registered manager spoke with us about the links they had built with the community for the benefit of the people living at Autumn House. For example, they had recently contacted a local support group for people living with dementia, and planned to make use of their consultation room through regular meetings with the group.

Duty of candour requirements were being followed; these required staff to act in an open and transparent way when accidents occurred. The manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed prominently in the home.