

## 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?	<b>Requires Improvement</b> 
Is the service effective?	<b>Requires Improvement</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Good</b> 

# Summary of findings

## Overall summary

### About the service

Athelstan House is a care home providing personal and nursing care to 50 people aged 65 and over at the time of the inspection. The service can support up to 80 people over four units.

The units were known as 'households', and one household was not open at the time of the inspection, due to redesign and full refurbishment. One household was for people requiring nursing care. There were two households for people with residential care needs and the refurbished household was designed to support people with dementia.

### People's experience of using this service and what we found

Risks to the safety of people who had been assessed as requiring a pureed diet due to swallowing difficulties were not always well managed. We found one person was served a meal which was not in accordance with their dietary requirements four times in two days at lunchtime. Upon receiving our feedback about this, the management team consulted with the kitchen staff and implemented monitoring systems to prevent this happening again.

People and their relatives gave mixed feedback about whether there were enough staff available. The home was staffed according to their dependency calculations. The home was actively recruiting for more staff and there had been successful recruitment initiatives at the home. To improve consistency in staffing on the nursing household, agency nurses had been block-booked. For people to feel there were enough staff, these changes may need more time to become embedded.

We also received varied feedback about whether call bells were responded to promptly enough. There was a new call bell system which gave a transparent oversight of how long people had been waiting. However, we did receive feedback from people who required the support of two members of staff for using the bathroom. They felt their call bell was answered by one staff member, but they continued to wait for a second staff member to become available. This had left people feeling embarrassed due to not receiving timely continence support.

People's feedback about the quality of the food they received was very mixed. The manager had introduced a group for people to attend called 'food for thought'. The food for thought group discussed feedback about the food and menu options they would like to see.

There were plans to implement more detailed care plans to support people's healthcare needs, such as epilepsy and diabetes. There was a consultant clinical lead working with the nursing and care staff to ensure the care plans reflected the healthcare support people required.

People had access to a visiting GP. The GP told us there had been improvements at the home and they felt the staff team were responsive to any guidance or feedback they gave.

There had been investment in the decoration and design of the inside and outside of the home. There were new carpets and kitchen/dining rooms, and landscaped gardens. We saw people using the gardens for walks and to spend time with friends or relatives. The gardens had won a community 'in bloom' competition.

There was an activity programme in place and an activities team of staff. People told us they attended activities where they wanted to. Activities also included community involvement, with a visiting toddler group spending time with people in the home.

People's relatives were welcome to visit when they chose. People's relatives attended meetings about the home. They told us they felt improvements had been made, although sometimes these were done at a slow pace.

People's privacy and dignity was respected by staff. People told us they could choose where they wanted to spend their time.

People's capacity to consent to their care was assessed in accordance with the principles of the Mental Capacity Act. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People, their relatives, staff and visiting professionals told us the morale and atmosphere at the home had improved in the six months prior to the inspection.

Audits of the service were completed by members of the management team and these gave the manager an oversight of the service. The manager knew where there were areas for improvement and there were plans in place to continue to address these.

The manager led by example and ensured they were a visible presence around the home. People and their relatives knew the manager and felt they were approachable. The manager had a good insight into people's needs and their life history.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Why we inspected

This was a planned inspection based on the previous rating.

#### Rating at last inspection (and update)

The last rating for this service was requires improvement (published 15 June 2018) with a breach of Regulation 12 for safe care and treatment. Since this rating was given, there was a change in manager and the provider notified us of action they would take to make improvements.

At this inspection we found improvements had been made and the provider was no longer in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections. More time was needed for some of the planned improvements to be implemented and embedded into practice.

#### Follow up

We will meet with the provider following this report being published to discuss how they will make changes

to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Details are in our effective findings below.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

Details are in our caring findings below.

**Good** ●

### Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

**Good** ●

### Is the service well-led?

The home was well-led.

Details are in our well-led findings below.

**Good** ●

# OSJCT Athelstan House

## 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.

#### Inspection team

The inspection was carried out by two inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

#### Service and service type

Athelstan 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.

The service had a manager awaiting registration with the Care Quality Commission. Registering with CQC means that they 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

This inspection was unannounced.

#### What we did before the inspection

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We also used information from notifications we received from the provider and people who gave feedback about the service. This information was used in our inspection planning and helps support our inspections.

#### During the inspection

We spoke with 12 people who use the service and nine relatives or visitors about their experience of the care provided. We spoke with 13 members of staff including the manager, area operations manager, peripatetic manager, consultant clinical lead, bursar, activities staff, nurses, care staff and housekeepers. 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 also spoke with one visiting healthcare professional.

We reviewed a range of records. This included 11 people's care plans and records, as well as multiple repositioning, cream and medication charts. We looked at four staff recruitment files and nine agency staff files, as well as records relating to staff supervision. A variety of records relating to the management of the service, including audits, meeting minutes, and accident reports were reviewed.

#### After the inspection

We received written communication from two people's relatives who were unable to share their feedback with us during the inspection.

# 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. Although there were improvements, some aspects of the service were not always safe and there was a risk that people could be harmed.

### Assessing risk, safety monitoring and management

- At the last inspection, the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people were not managed safely. At this inspection we found improvements had been made to the risk assessment and review process and the service was no longer in breach. Risks to people's safety were recorded in risk assessments. These included measures for staff to follow to reduce risks occurring.
- One person's food was not prepared according to their assessed dietary requirements, to reduce the risk of choking. On the first day of the inspection, we saw the person being given the wrong meal twice, despite them requiring a textured diet due to their risk of choking. After they had been served the correct meal, the person told us they were only able to eat one part of it, due to large lumps. On the second day of the inspection, the same person was served food again that was not prepared appropriately according to their assessed needs. The person had capacity and was able to recognise foods that posed a risk to their safety and wellbeing. However, there may be people with dietary needs who would not recognise the risk. The manager acted upon the concerns by speaking with the chef and staff who prepared and served the meals.
- Risks associated with fire, gas or water were assessed and monitored. We saw appropriate and up to date testing, including legionella checks had taken place.

### Staffing and recruitment

- We received mixed feedback about how long people waited for their call bell to be answered. A new system had been installed, which made the call bell response times easier to monitor. The manager explained there had been some issues getting used to the system, however this was now working more accurately. We saw in the care offices and the manager's office there were monitors which showed how long call bells were ringing for. We monitored these and saw records which showed call bells were responded to in an efficient manner during the inspection.
- We received mixed feedback about whether there were enough staff on duty. Three people told us although their call bell was answered, where they needed the support of two carers, this caused a further delay. One person told us this had resulted in them feeling "humiliated" due to not receiving timely continence support.
- There were some positive comments, where people or their relatives told us the staffing numbers and consistency had improved. Their feedback included, "There are more staff on the nursing unit now, although still quite a lot of agency staff." Also, "[Manager] has increased the number of staff members on duty, especially at meal times." The manager showed us the home was staffed according to their dependency tool, which took the layout of the building into consideration.
- The manager analysed call bell reports monthly and followed up where people had been kept waiting. The

manager sent us further analysis of call bell response times after the inspection and this showed call bells were responded to in mostly less than 10 minutes.

- There had been a lack of consistency in nursing staff. In the week following the inspection, two block-booked agency nurses were due to start work at the home. Their appointments had been subject to the same interview processes as permanent nurses.
- Safe staff recruitment processes were in place. New staff were offered positions subject to satisfactory employment and character reference checks, as well as disclosure and barring service (DBS) clearance. The DBS helps employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people.

#### Preventing and controlling infection

- We observed the home to be clean and free from unpleasant odours throughout. However, some people and their relatives told us this was not always the case. Their comments included, "The table is not often wiped and is sticky", "There are often dirty dishes left in the room and crumbs on the carpet. Sometimes the bed linen doesn't look clean."
- There was a housekeeping team responsible for maintaining the cleanliness of the home. We received some positive feedback about the housekeeping team. One person told us, "I cannot fault the cleaning or laundry service, both are excellent." Another person said, "My bathroom is kept spotless. There are also no smells in the home, that you get in some places."
- Staff had access to and we observed them using personal protective equipment (PPE). This included gloves, aprons and antibacterial hand gel.

#### Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe at the home because of the staff. One person said, "I feel safe because the staff are very good, the feel of the place is good, and it is very secure here. I don't have the worry of looking after a house and making sure I lock up like I did at home."
- People's relatives and visitors told us they felt the home was safe. One person's visitor told us, "I have never witnessed anything that I felt to be unsafe at all."
- Staff understood their responsibility to identify and report any safeguarding concerns.
- Staff knew who they could report their concerns to within the service and provider, as well as external agencies such as CQC and the local authority safeguarding team.

#### Using medicines safely

- At the last inspection, the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not managed safely. At this inspection, we found improvements had been made and the service was no longer in breach. Medicines were managed, stored and administered safely, this meant people received their medicines as prescribed.
- People had protocols in place for medicines administered on an 'as required' basis. These detailed when medicines should be administered. Protocols also included if the person could tell the staff when they required these medicines, or if staff needed to identify the person's need.

#### Learning lessons when things go wrong

- Accidents and incidents were recorded by staff and reviewed by the head of care and the home manager. Where measures could be implemented to reduce the likelihood of the accident recurring, these were put in place.
- There was a risk register for each household in the home, which was used to review the risks for each person and record whether there were any updates.

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. Although there were improvements since the last inspection, further work was needed to ensure the effectiveness of people's care, treatment and support to achieve good outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People with diabetes, Parkinson's, and epilepsy did not have detailed enough specific care plans in place for these healthcare needs. This meant staff may not have access to the support, guidance and information required when supporting the person. This shortfall had been identified by the consultant clinical lead and formed part of their action plan for improvements at the home.
- People's needs were assessed prior to their admission to the home. One person told us, "I was interviewed at home before I came here, they took all the details of my likes and dislikes. The permanent staff know me pretty well and how I like things done." Another person said, "When I first came here, they asked me all about me, my past life and interests, and my likes and dislikes."
- People's care plans were reviewed on a 'resident of the day' basis, where during the day, staff ensured all documentation and assessments were up to date. The manager spoke with us about their plans to develop this process as they wanted the person to feel "extra special" when they were resident of the day. Their plans included the person putting a suggestion forward for the lunchtime menu.

Supporting people to eat and drink enough to maintain a balanced diet

- We received varied feedback about the quality of the food. The comments received from people ranged from the very positive, to the very negative. For example, one person told us, "My biggest complaint is the food." However, another person said, "The food is excellent, it's too good!" People with concerns about the food also told us the vegetables were hard, the meat was tough and "we don't get our five a day."
- We passed feedback from people about the food to the manager. This included one person who is vegetarian feeling concerned about the fat content of the vegetarian options and their worries about a lack of protein. The manager invited the person to join the home's 'food for thought' group. The group act as a food committee to discuss the menu's and put suggestions forward.
- When we raised concerns with the manager and the consultant clinical lead about the quality and consistency of pureed food, they immediately raised these with the chef. One person told us, "I have pureed food and I wish they would tell me what it is I am eating."
- There were 'snack stations' throughout the home. These had a choice of grab and go snacks for people to choose from, such as crisps, chocolate bars and fruit.
- People had access to drinks. We saw people had a choice of cold drinks throughout the day available to them, including water in their bedrooms. People were offered hot drinks by staff throughout the day as well.
- One complaint had been received where staff had given drinks in cups which were too heavy for a person to use. This had meant the person could not drink independently and the cups of cold tea were found in the person's bedroom by their relative. This complaint had been communicated to staff, to reduce the

likelihood of these events recurring.

- Where people were assessed as being at risk of dehydration or malnutrition, records of their food and drink intake were in place and maintained by staff. The records gave an overview of how much the person had eaten or drank.
- People were supported with equipment to eat independently. This included plate guards to create an edge to the plate. Also, raised tables for people in larger wheelchairs, enabling them to sit closer to the dining table and sit with others while they ate their meal.

Staff support: induction, training, skills and experience

- There was a staff trainer working with the home to help ensure all staff had attended their mandatory training. There were some gaps in staff training attended, but there were plans in place to address this.
- Staff received training in a range of different areas. This included, the Mental Capacity Act, safeguarding, fire safety, and infection control. Senior staff on units without registered nurses completed training in medicines management. People told us they felt the staff had received enough training to support their needs.
- Staff told us the manager supported them to develop and gain vocational qualifications. One staff member explained they wanted to achieve their level three award in health and social care. They said, "I want to develop here, I have a good career in care working here."
- There were support systems in place for staff, to ensure they were up to date on communications and to discuss individual and team development. Staff had one to one supervision meetings and also attended handover and team meetings. Staff told us they found the handover documentation between shifts to be useful and detailed.

Adapting service, design, decoration to meet people's needs

- People had access to communal living areas, including a large and accessible kitchen area in each household.
- Areas of the home had been or were in the process of being redecorated and re-carpeted.
- One household in the home had been closed for over one year, while it was developed to meet the needs of people with dementia. The household had been re-designed using guidance from the University of Sterling and consideration had been given to the colours and furnishing. This household was due to open in the week following the inspection.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support

- Referrals were made to health and social care professionals, with their guidance then included in the person's care plan. For example, where people were at risk of choking, they had been seen by a speech and language therapist.
- There were clinical professionals working with the home. This included a consultant clinical lead, who was working with the home to identify areas for improvement and implement good practice. The home also had a visiting admiral nurse. The admiral nurse was a specialist dementia nurse, who worked with people, their families, and the staff team to meet people's needs.
- People had access to regular visiting GP's and could request to be seen by the doctor during their visit. One GP told us, "Things have definitely got better in the past year. Previously there were some nurses who were resistant to change but they have now left. There are more regular nurses and I am impressed with the carers. Staff now flag things up with us and take on board what we ask of them. All contact with us is appropriate and in a timely manner. I genuinely only have positive things to say."
- People's healthcare needs were monitored and where their needs changed, the relevant health and social care professionals were contacted.
- Where people were at risk of pressure sores or skin breakdown, records showed they were supported to be

repositioned regularly. People with pressure relieving equipment such as mattresses had these checked daily, to ensure they were at the correct setting.

- People had treatment escalation plans in place. These plans were completed by the GP and included consultations with the person, or where appropriate their representative. The plans gave guidance about the person's treatment such as resuscitation and hospital admission.

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Where people lacked the mental capacity to consent to decisions relating to their care and treatment, assessments and best interest decisions were in place.
- There were records maintained of DoLS applications sent to the local authority and awaiting approval.
- Staff were aware of the principles of the MCA and knew how to apply this to their role.
- We saw people being asked for their consent, prior to staff supporting them.

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us they felt most staff were helpful, kind and friendly. One person told us, "The staff cannot be faulted, their readiness to be helpful and how pleasant and understanding they are, it makes a big difference." Another person said, "I am extremely happy here, generally the staff are excellent, they are kind and approachable."
- Three people told us they felt some staff could be more empathetic. One person said, "Just one or two need to be a bit more understanding. They aren't unkind, they need a little more empathy." A different person explained, "Some of the staff are very caring and understanding, but some don't seem to have much empathy, particularly at night."
- Some relatives told us they felt well supported by the staff as well as the consultant clinical lead and admiral nurse. One person's relative told us, "The staff look after the relatives, as well as the residents, they want us to be happy too." Another relative said, "The staff are always there for you, as well as the residents. A few of the relatives have found it hard to cope with the changes in their loved ones, but we have been so supported by the admiral nurse. The support is there if you need it." A different relative explained, "I have a close relationship with the team, they support me as well as [family member]. I have found it really helpful talking to the [consultant] clinical lead and the admiral nurse."
- People's diverse cultural beliefs were understood and respected. One person had been supported to have prayers played on a cassette player, in their first language.
- People's birthdays were celebrated. There was a volunteer who prepared a cake with personalised decoration at the home, for each person.

Supporting people to express their views and be involved in making decisions about their care

- People told us staff respected their day to day choices, such as where they wanted to eat their meals. One person told us, "I prefer to go down to the dining room for lunch and I stay in my room for my other meals, that's alright, they accept my choice."
- Most people and their relatives told us they were involved in their care planning and decisions about their care. One person said, "I go through my care plan with [the key-worker], we did it yesterday and I am happy with what is written in there and agree to it all."
- People had staff assigned as key-workers and in the nursing household they also had an assigned nurse. Key-workers were staff members responsible for ensuring information held about the person was up to date and the person had access to everything they needed.

Respecting and promoting people's privacy, dignity and independence

- Signage was used around the home to help promote people's dignity and privacy. This included privacy signs for bedroom doors and signage to help identify bathrooms.
- We observed staff respecting people's privacy. Staff knocked on people's bedroom doors before entering. We saw one staff member knock on a person's door before asking them if they would like support to have a bath. The person declined, and the staff member let them know they were welcome to choose a different time if they would prefer.
- People told us when they were being supported with their personal care, it was done so with dignity. One person explained, "If I am having a wash, the staff make sure the towel keeps me covered over the parts they are not washing."
- People told us staff knew and respected their wishes about which gender of staff member they would prefer to be supported by. Where people had not wished to have the opposite sex provide them with support, this had been respected.
- People chose where they wanted to spend their time. We saw people using the gardens, spending time in the main foyer, visiting the hairdresser, or in the lounges. The gardens had been designed to be accessible and user friendly, with a pathway that enabled people with mobility aids to access the grounds. One person said, "It is a lovely thing here, you can be completely private in your room and listen to the radio, read or watch television, or see visitors and be undisturbed. Or, you can go and be with other people, it is up to you."

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's religious beliefs were known, respected and supported. There were services which took place in the home. Also, people could be visited by a local priest or vicar. One person said, "There is a Sunday service and I have Holy Communion in my room once a month, which I am very pleased about."
- Staff and the manager knew people and their life histories. The manager and staff took time to discuss these with people. The manager introduced us to people including one person who had achieved their pilot licence at 80 years old, also another person who had worked as a teacher for many years. People enjoyed engaging in conversation with the staff and manager about this.
- People's care plans included information about their likes, dislikes and what support they needed from staff. For example, in one person's care plan the information about their morning routine included, 'Please give me a cup of tea in bed, as I like to have it before getting up.'

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- One person who was receiving care in hospital at the time of the inspection, had been visited by a translator. Together and with involvement from the person's family, communication cards had been put in place. This helped staff support the person in their first language.
- Technology was used to add to the environment and support people's communication needs. There were interactive, voice-controlled devices which could play music when asked, situated around the home. Staff told us people interacted with these and the devices were used during activities as well. The devices could provide information upon verbal command about the weather and news.
- Where people required communication aids such as glasses, their care plans clearly detailed this, so staff could provide them with the appropriate assistance.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People and their relatives told us they felt there could be some improvements to the activities programme. One person and their relative told us they felt there could be activities aimed more towards what men wanted to do. Another person's relative also felt the activities were not aimed at their father's interests. They said, "There used to be a male housekeeper who would talk to dad about the football, which he loves, I think

he misses that man to man contact." A different person told us they felt there could be more outings.

- There were activities staff delivering a programme of group and one-to-one sessions. One person told us, "I go to the knitting circle and the art class, which I enjoy." Another person said, "There's plenty going on. They do come and ask me if I want to join in. They bring the [pets as therapy] dog to see me." A different person explained, "They have the toddler group come in, which people love. It changes people's mood completely."
- We observed some of the toddler group known as 'messy miniatures' visiting the home and saw people engaging with the children and their activities. People also spent time chatting with the children's parents, in the large day centre room at the service.
- Additional community involvement came from the well-maintained gardens. The home had won a community 'in bloom' competition and the garden spaces were creatively designed.
- The day centre room provided a large space for activities to take place, with lots of seating and an in-house shop. The shop had items such as toiletries for people.
- In addition to the activities staff, there were external entertainers visiting the home.
- There were plans to develop the activities provision at the home. The manager explained they would like to have an activities coordinator dedicated to each household in the home.
- People's relatives were welcomed to visit their family member at the home when they chose. Relatives told us this had been helped by improvements in staffing on the home's reception desk.

Improving care quality in response to complaints or concerns

- Complaints were responded to within the 28-day provider's policy. The manager told us they like to deal with complaints "straight away". They told us they like to meet with the person making the complaint or communicate with them via email or letter.
- The peripatetic manager was the provider's lead for complaint management. The manager communicated with the peripatetic manager where complaints had been received and advised them of the action taken.
- There were no open complaints at the time of the inspection.
- There was a group for people's relatives, known as the Athelstan Development Team. The group discussed any concerns or developments at the home and regularly met with the manager. Some relatives told us they felt there had been improvements and felt the current manager had a positive impact over the changes moving forward.

End of life care and support

- At the time of the inspection nobody was receiving end of life care and support.
- People had end of life care plans in place where their advanced wishes were recorded.

# 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 requires improvement. At this inspection this key question has now improved to good. Although there were areas for improvement identified in safe and effective, the manager responded in a timely manner to our feedback. The service was no longer in breach of regulations and was consistently well managed. Leaders and the culture they created promoted high-quality, person-centred care.

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

- A positive and person-centred culture was fostered by the manager's approach. The manager told us they led the service by "leading by example" and they manage the home "by walking the floor." They explained, "My strategy was to change the culture, to make it so the team can buy into [a person-centred] approach and it is a whole home approach."
- The manager aimed to speak with or see every person who lived at the home at least three times per day. We observed them chatting, engaging and laughing with people throughout the home and they clearly knew people well. One person said, "The manager is very visible and approachable. People like him, there has been a positive change in the last six months, there is more openness." Another person told us, "The manager is about all the time, he is very visible, and we haven't been used to that previously. [Family member] will say, 'he has been in to see me today' and it must also be good for staff morale too."
- The manager had encouraged group meetings to discuss creative ideas for the home and the future. They had started the 'food for thought' group and as a result, a 'night owl' menu had been introduced. The aim of the night owl menu was to support people who may wish to eat later in the evening or at night.

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 manager fully understood their responsibility to act upon their duty of candour.
- There was open communication with people's relatives, evidenced in the way complaints were responded to.
- The home notified the local authority safeguarding team and CQC of any important events, where things may have gone wrong.

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

- Staff and professionals visiting the home told us there had previously been a lack of morale in the staff team, but in the recent months prior to the inspection they felt this had improved. The manager said, "Morale is high, short-term staff sickness has gone down. The staff team are happy, and the residents tell me when they have issues." The manager explained, "This home is on a journey."
- The manager had high expectations they were developing staff to achieve. This included their plans to

have care staff more engaged in activities and to see this as part of their care role.

- The home was supported by the provider. This support included a peripatetic manager who visited the home regularly, as well as an area operations manager and a quality team. There was also an admiral nurse who worked with the provider's homes local to the service, as well as a regional trainer and an in-house bursar, and head of care.
- The quality team visited the home and carried out audits of different areas. The findings from this then led into an overall home improvement plan, which the manager maintained an oversight of. Findings from these visits showed improvements were being made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others

- The bursar and head of care were responsible for overseeing different teams within the home, conducting audits and staff supervisions.
- The home had good relationships with the local community and had received donations. The money donated had been used for new shower chairs and there were plans to use a donation for an interactive activities table. The manager told us, "The community involvement has been brilliant, it is really fantastic here."
- The Athelstan Development Team consisted of five relatives and had regular meetings with the manager. The manager told us, "With the garden, [people and relatives] formed a focus group. When the landscaper came, he could not finalise anything until he had met with them. They are heavily involved in the gardening."
- People, their relatives and staff attended meetings to discuss communication updates about the home, raise any concerns and talk about ideas for the future of the home.
- Volunteers supported the staff team and the manager had plans to further develop this resource. They told us the volunteers came to them via recommendations from people's relatives, or they had once had relatives live at the home.

Continuous learning and improving care

- While in the absence of a permanent clinical lead, the manager had appointed an independent consultant on a temporary basis. They told us, "The plan is for [the consultant clinical lead] to put systems in place." We saw this happening when speaking with the consultant clinical lead and they discussed the areas they had identified for improvement. There were realistic and set reasonable time frames to implement these changes and embed positive changes at the service. These improvements included ensuring good clinical governance and consistency in nursing standards on the nursing household.
- The manager and consultant clinical lead understood the need for more consistency in nursing staff, to ensure the changes were thoroughly implemented. This was an area where the service had previously failed to consistently embed good practice, due to changes in staffing. To address this, the block-booked agency nurses had been appointed, while permanent nursing staff interviews took place.
- Audits of the service were completed by heads of departments or senior staff and reviewed by the manager. These identified the areas for improvement which we found during this inspection, other than the risks associated with the pureed food. Following our conversations with the management team about the pureed food, we were advised further training will be implemented and the standards will be monitored.