Care Quality Commission

Autumn House Nursing Home Limited

Autumn House Nursing Home

Inspection report

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14 November 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Autumn House Nursing Home (known to people using the service, their relatives and staff as Autumn House) on 13 and 14 November 2017. The first day of inspection was unannounced. This meant the home did not know we were coming.

Autumn House is registered to provide nursing and residential care for up to 41 people. When we inspected, 36 people were using the service. The building is a converted older house with two floors. At the time of this inspection the service was being reorganised so that there would be three units: a higher dependency unit for people living with dementia, a lower dependency unit for people living with dementia, and a residential unit. Each unit had a communal lounge, toilets and bathing facilities.

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

The registered provider for Autumn House changed in October 2016; this is the first inspection of the home since then.

The home had a registered manager. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's care plans did not always contain sufficient detail to inform staff how to support them safely and staff did not always follow people's care plans when providing support.

We observed three people were supported to transfer by staff using handling belts in an incorrect and unsafe manner. We reported this to the registered manager who said he would address this with staff.

Some parts of the home were not clean. We recommended the registered manager update infection control procedures in accordance with nationally recognised good practice.

Accidents and incidents were recorded correctly and the registered manager had oversight of them. He also analysed information for trends and patterns.

Most aspects of medicines management were undertaken safely, although we did identify some areas of concern.

Sufficient staff were deployed to meet people's needs, however, staffing levels were not based on a dependency tool which included each person's assessed needs. We recommended the registered manager

implements a dependency tool to confirm staffing levels deployed are adequate. The process of recruitment was robust.

Checks on the building, its equipment and utilities had been completed appropriately.

The service was compliant with the Mental Capacity Act 2005, although we identified some concerns around staff knowledge and documentation. Evidence was not collected from people's relatives and friends who said they had Lasting Power of Attorney for people, in order to confirm this.

Feedback about the food and drinks served at Autumn House was positive. We observed people did not receive a choice of main course or drinks at mealtimes and support provided to people was task-focused rather than person-centred.

Staff received the induction, supervision and training they needed to meet people's needs.

Records showed people had seen a range healthcare professionals, such as GPs, community nurses and dieticians, in order to meet their wider health needs. Most feedback we received from healthcare professionals we contacted about the home was positive.

Good practice on dementia-friendly environments had been used when updating and improving the building.

People and their relatives told us staff were kind and caring. Most interactions between staff and people we observed were positive, although we observed some staff supporting people living with dementia lacked knowledge of how to do this effectively.

People were supported to remain independent. They also had access to advocacy services if they needed help to make decisions.

Most people and relatives we spoke with told us they had been involved in developing and reviewing care plans, or had been asked to contribute. Records we saw did not evidence this. The registered manager agreed documentation could be improved to reflect people's involvement.

People told us they had enough to do at Autumn House and praised the efforts of the activities coordinator. Records showed, and we observed, people had access to a wide range of activities both inside and outside the home.

People and their relatives felt confident to complain if they needed to. No complaints had been made by people or relatives since the change in registered provider in October 2016.

A range of audits were in place to monitor safety and quality, however, these had failed to identify the concerns we raised at this inspection.

People, their relatives and staff had opportunities to provide feedback about the service and were actively involved in decision-making. The registered manager fostered an open and inclusive culture at the home which respected people's equality and diversity.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's care plans did not always contain sufficient detail about risk management. Care staff did not always follow people's care plans when providing support.

The building, its utilities and facilities had been checked for safety, but not all areas were clean.

Some aspects of medicines were not managed safely.

Sufficient staff were on duty to meet people's needs and recruitment procedures were robust.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was compliant with the Mental Capacity Act 2005, although we identified some concerns around staff knowledge and record-keeping.

Feedback about the food and drinks at the home was positive. We saw people were not routinely offered choices and did not always receive person-centred support to eat.

Staff received supervision, appraisal and training to support them in their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives told us they had been involved in developing their care plans but records did not reflect this.

People and relatives told us staff at the home were caring. The atmosphere at the home was homely.

People were supported to retain their independence by staff; this was reflected in their care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's care plans lacked detail, whereas others were informative and person-centred.

We saw, and records showed, people took part in activities in the home and out in the community. People praised the efforts of the activities coordinator.

No complaints had been made about the service by people and their relatives. People told us they felt confident to go to the registered manager or other staff if they had a problem.

We observed staff had a person-centred and empathetic approach to end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A comprehensive system of audit was in place but it was not always effective in identifying concerns and driving improvement.

Feedback about the registered manager was positive. We saw he promoted an open and inclusive culture at the home.

People and their relatives had opportunities to provide feedback about their experience of the service.

Care Quality Commission

Autumn House Nursing 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 13 and 14 November 2017. The first day of inspection was unannounced. The inspection team consisted of two adult social care inspectors and one expert by experience on the first day of inspection, and one adult social care inspector and an assistant inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had 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 improvements they plan to make. We used this to help plan the inspection.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Barnsley, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. After the inspection we received feedback from two healthcare professionals who visited the home to support people there.

During the inspection we spoke with eight people who used the service, six people's relatives, four members of care staff, the registered manager, the activities coordinator, a kitchen assistant and a cook.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of

people using the service who could not express their views to us.

As part of the inspection we looked at five people's care files in detail and selected documents from eight other people's care files. We also inspected three staff members' recruitment and supervision documents, staff training records, six people's medicines administration records, accident and incident records, and various policies and procedures related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People at Autumn House told us they felt safe. One person said, "I am much safer living here than when I was at home", and a second person told us, "The staff do all they can to make you feel secure." People's relatives felt their family members who used the service were safe. Comments included, "They make [my relative] feel happy and safe", and, "I think [my relative] is safe here."

As part of this inspection we checked the systems in place for the management and administration of people's medicines; this included observing a medicines round. Nurses administered medicines at the home. We observed the nurse administering medicines was polite and supportive; they explained to people what their medicines were for and did not rush them. We saw when two people were provided with their medicines the nurse did not stay to confirm they had been taken; when we asked the nurse explained both people preferred to take their medicines in their own time and had mental capacity to make this decision. We saw this was recorded in their care records. This meant medicines were administered in a person-centred way.

A safe system was in place for the ordering, receipt and return of medicines, and most prescribed medicinal items were suitably stored. However, we did note issues with storage as people receiving nutrition via percutaneous endoscopic gastrostomy tubes (PEG tubes) or who used urinary catheters had equipment stored on the floors of their rooms. These were often located alongside packs of continence pads, which were also stored on people's bedroom floors. The registered manager told us he would arrange for more appropriate storage of such items.

Most medicines were supplied in pre-dispensed blister packs, although some liquids and medicines prescribed 'when required' were in bottles and boxes. 'When required' medicines are taken by people when they experience particular symptoms, for example pain, and should be accompanied by care plans which describe when and how often people should take their 'when required' medicines. People's medicines administration records (MARs) evidenced their medicines had been administered as prescribed, however, we noted care plans for 'when required' medicines lacked detail. For example, information on what the medicine was for or the person's symptoms or behaviours when they needed it were not always recorded. We also noted the nurse administering medicines did not look at people's MARs as they prepared medicines ready for people to take. The nurse also prepared three people's medicines to be administered by their PEG tubes at the same time using different coloured cups. This was unsafe practice, as people's medicines must be checked against their MARs to ensure blister packs contain all the tablets they should and the correct amount of any boxed or bottled medicines are administered. Medicines for different people should never be prepared at the same time as this can lead to medicines errors. This meant people's medicines were not always checked safely prior to their administration.

We checked the management, storage and stock levels of controlled drugs at Autumn House and identified no concerns. Controlled drugs are controlled by legislation and include medicines such as strong pain-killers. However, when we tried to reconcile three medicines prescribed 'when required' we found there was no ongoing tally of the amount in stock and nurses had not always recorded the number of tablets they had

administered each time. This meant it was not possible to calculate the amount which should be in stock.

We also identified concerns with the recording of people's topical medicines, such as creams and lotions. When we arrived on the first day of inspection we found a basket in a communal bathroom which contained several people's part-used creams. We also found a cream prescribed for one person in the room of another. MARs for creams did not always evidence people had received their creams as prescribed. For example, one person's MAR for their topical creams had a handwritten instruction for it to be applied to 'dry areas' in the morning, whereas their main MAR said the cream should be applied to affected areas twice a day. We also found not all prescribed creams had topical MARs for care workers to record their application. This meant it could not always be evidenced people received their topical medicines as prescribed.

Concerns with medicines administration and documentation were a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns around medicines management to the registered manager. Two days after the inspection he sent us an action plan which showed additional staff training and supervision was planned by the end of November 2017.

Whilst most parts of the home were clean and odour-free, we found some parts were not. We arrived early on the first day of inspection and checked the bathrooms and toilets. In one bathroom we found obvious faecal staining on a bath hoist and door handle. In two bathrooms we found shower chairs were very rusty and dirty underneath. In a toilet we found a bin for continence waste was a quarter full but had no bin bag inside; faeces were smeared down the inside of the bin. None of the toilets had toilet roll holders; toilet rolls were stored on radiators, or shelves just above floor level. We found faeces inside the tube of one toilet roll that was in use. When we checked the cleanliness of wheelchairs we found some smelled strongly or urine and/or faeces and one had visible faecal smears on the seat. We fed this back to the registered manager straightaway and he resolved to make sure all areas we identified were cleaned. One healthcare professional we spoke with after the inspection told us they had noted the same issues. They said, "The toilets are not always clean, especially on the dementia side. The bins are often mucky there."

At the end of the second day of inspection we checked the same areas again with the registered manager. The bath hoist was cleaner, although some soiling remained down the side of one arm. The bin for continence products we had seen without a bin bag on the first day had a bin bag on the second day, however, the faecal staining inside the bin remained. Most wheelchairs smelled fresh, however, the one with the stained seat had not been cleaned. The registered manager ordered two new shower chairs for delivery two days after the inspection.

Areas of the home were not clean and action taken in response was not always adequate. This was a breach of Regulation 12 (1) and (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two days after the inspection the registered manager sent us an action plan which showed infection control audits were to be updated to increase the efficacy of monitoring. In addition responsible staff were to receive training and supervision. All actions were for completion in November 2017.

We saw a range of risk assessments in each person's care files, covering aspects such as mobility, nutrition, skin integrity and falls. During the inspection we saw measures were in place to reduce risk to people; for example, one person at risk of falls had a chair sensor which alerted staff when they stood up. We saw staff responded quickly when this alarm sounded. People had care plans which included any control measures

required to minimise risks identified. We saw some people's care plans were up to date and contained adequate person-centred information to guide staff on how to support them safely; however, others were not. For example, one person's nutrition care plan dated March 2017 stated they needed their fluids thickened for safe swallowing; there was no mention of a required food consistency for safe swallowing. We noted a letter from speech and language therapy dated August 2017 stated the person needed a pureed diet and thickened fluids to reduce their choking risk. A letter dated May 2017 stated the person needed fork-mashable foods and when we asked a care worker, that is what they told us the person needed. This meant the person was at risk of choking as up to date guidance from speech and language therapy was not followed. We informed the registered manager and he ensured the care plan was updated immediately and all staff were informed.

We noted skin integrity risks to some people were reduced by the use of air mattresses. The nurse we spoke with could describe how to set the mattresses correctly, but we saw settings were not included in people's care plans. One person's air mattress was set at twice their actual weight, which meant it would be firmer than required, thereby placing them at increased risk of pressure ulcers. We informed the registered manager who adjusted the mattress immediately and reviewed all air mattress settings so that people's care plans could be updated with them.

People who needed hoists to transfer had appropriate risk assessments and care plans in place, which included instructions on how to apply the slings. However, during the inspection we observed three incidents where care workers assisted people to transfer using handling belts in an unsafe manner. Handling belts are to be used to support people, not to lift them. We observed staff used handling belts to pull people up from sitting on three occasions, and when standing, one person was very unsteady, and a second person was not fully weight-bearing. When we checked each of the three people's care plans, handling belts were not mentioned. One of the three people's care plans stated they could transfer with two members of staff; when we asked another member of staff how they transferred this person, the care worker told us they were hoisted. This meant care staff did not always follow people's care plans when supporting them to transfer.

These examples constitute a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had regular fire drills and records showed checks on fire equipment had been made as required. During the inspection the fire alarm went off due to burned toast in the kitchen. We saw staff responded appropriately and the registered manager had a coordinating role. People had personal emergency evacuation plans (PEEPs) in their care files; however, there were no copies in the home's 'grab bag' which contained other emergency information. PEEPs contain information on how to safely support people to evacuate the building and are important when emergency personnel unfamiliar with people are providing support. The registered manager said he would ensure copies of people's PEEPs were added to the grab bag as soon as possible.

When we arrived on the first day of inspection we noted the doors of several people who were in bed were propped open, either with wedges or chairs. The registered manager said it was so staff could make observations and ensure people's safety. This was not safe, as the doors were fire doors and so people may not be protected in the event of a fire. The registered manager immediately ensured all fire doors were closed and we saw this was maintained throughout the remainder of the inspection. This meant systems were in place to ensure people's safety in the event of a fire.

People told us there were always enough staff on duty to meet their needs. One person said, "There are enough staff, this makes you feel safe", and a second person told us, "You can call for help anytime, staff

come straightaway." Relatives agreed there were enough staff deployed. One relative said, "There's loads of staff here. They're a bit stretched sometimes 'cos (because) there's loads to do." Staff at the home told us they felt staffing levels were adequate. Comments included, "I would say there's enough staff on shift here. Jobs always get done and everything's generally all OK", and, "Staffing levels are OK. We keep busy but generally I would say it's OK."

The registered manager told us staffing levels consisted of one nurse at all times, with six care workers in the morning, five care workers in the afternoon and three care workers at night. Rotas showed shifts were fully staffed. At the time of this inspection the home was changing from two units to three units, with a higher dependency unit for people living with dementia, a lower dependency unit for people living with dementia, and a third unit for those people nursed in bed and people with residential needs. The plan was for each unit to have two care workers. The registered manager was confident the changes would optimise staff availability but told us staffing levels were not based on a dependency tool, which used information on people's needs and calculated the required number of staff to meet them. He told us staffing levels were based upon observations and feedback from people and staff, but in response to our feedback the registered manager planned to investigate and implement a dependency tool. This meant whilst feedback from people, relatives and staff supported our observations that the number of staff deployed was adequate, the registered manager did not base staffing levels on a dependency tool.

We recommend the registered manager implements a dependency tool based upon the assessed needs of people using the service, and uses it to confirm staffing levels deployed are adequate.

As part of this inspection we reviewed the recruitment records for three staff employed by the home to check whether all the necessary pre-employment checks had been made. Records showed all aspects had been checked in accordance with the regulations, including taking up prospective employees' references and requesting a DBS check. The DBS, or Disclosure and Barring Service, helps employers make safer recruitment decisions. This meant recruitment procedures at the home were robust.

Care staff we spoke with had received training on safeguarding adults and could describe the ways in which people they supported may be vulnerable to abuse. They told us they would report any concerns to the registered manager. This meant staff helped protect people from abuse.

We checked records for the maintenance and upkeep of the home's building, utilities and facilities, for example, the gas supply, moving and handling equipment, and water temperatures. All checks and testing had been done as required. An emergency plan was also in place and stored where it was easily accessible to staff. This meant the registered manager ensured risks to people posed by the building were minimised.

Records showed appropriate action was taken in response to any accidents or incidents at the home, for example, falls. As part of his oversight of the home, the registered manager analysed information on any accidents or incidents on a regular basis in order to identify any patterns or trends so that prevention measures could be put in place or lessons learned. This meant the registered manager collected and used information to improve people's safety at the home.

Requires Improvement

Is the service effective?

Our findings

People told us they thought care staff had the skills and knowledge they needed to support them. One person said, "The staff really know what they're doing", and a second person commented, "All of the staff know just how to care for me. They have had training in all sorts of things."

People we spoke with also told us they made their own decisions. Comments included, "I am in control of my life; no-one else", and, "I get up and go to bed whenever I choose. I live my life the way I want to live it." As part of this inspection we reviewed what arrangements were in place for people who may lack mental capacity to make decisions, and how any decisions had been made on behalf of such people.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards or 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 people who lacked capacity to consent to live at Autumn House had DoLS authorisations in place or applications for DoLS submitted for them. All the DoLS we reviewed contained two conditions for the service to abide by. These appeared to be standard conditions added by the supervisory body (in this case the local authority) and related to the service making timely provision for the person to appeal their DoLS should they want to, and for the service to notify the supervisory body of any significant changes in the person's health. We noted each person had a pre-printed generic DoLS care plan in their care files which did not include the two DoLS conditions, although we found no examples of the service failing to abide by the conditions. The registered manager told us he would ensure DoLS care plans would be personalised in future and include any conditions imposed.

Records showed staff had received training on MCA and DoLS, however, we found staff knowledge of MCA and DoLS was poor. For example, one care worker told us none of the people in the higher dependency unit for people living with dementia had a DoLS in place and a second care worker told us they did not know which people had a DoLS. A third member of care staff told us MCA applied to all people at the home, including those who had mental capacity. This meant care workers lacked knowledge and understanding of MCA and DoLS.

Records showed consideration of people's mental capacity and ability to consent to their care and treatment had been considered by the service. Each section of people's care plans contained a mental

capacity assessment as to their ability to take part in their care planning for that area, for example, continence care, nutrition, or mobility. However, these assessments did not make it clear what the specific decision the person's capacity was being assessed for was. We also noted people who had mental capacity also had these assessments in place in their care files, evidencing a blanket approach to MCA was used. A guiding principle of the MCA is that all people are assumed to have capacity unless it is suspected they may not. We discussed these issues with the registered manager; he told us the home's approach to MCA would be reviewed to ensure documentation evidenced procedures in place were in accordance with the legislation.

We also noted the relatives or friends of some people who lacked mental capacity had been involved in planning their care or had signed consent forms for them. Records noted some of these relatives or friends had been granted Lasting Power of Attorney (LPA) to make decisions about their finances and/or welfare, but no evidence of this had been sought. This meant evidence was not routinely obtained to ensure people's relatives or friends had the legal right to make decisions on their behalf. We discussed this with the registered manager. Two days after this inspection he supplied an action plan which stated meetings would be held with all people and relatives by the end of 2017 to establish who had LPA and request evidence of this for the home's records.

Records showed staff had received regular training and updates on a range of subjects, including safeguarding adults, food hygiene, moving and handling, and fire safety. The registered manager arranged for newly recruited staff to access a seven day induction run by the local authority, which contributed to the Care Certificate, although most staff recruited already had nationally recognised qualifications in health and social care. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. New staff without nationally recognised qualifications in health and social care were encouraged to take such courses as part of their personal and professional development. Nurses at the home also had access to clinical training courses to maintain their competence, for example, with the use of syringe drivers and for urinary catheter care.

Staff we spoke with all told us they received regular management supervision and an annual appraisal. Records we saw confirmed this. Staff described supervision as a supportive process and useful in terms of their personal and professional development. This meant staff had access to the training and support they needed to provide people with effective care.

People told us they liked the food at Autumn House. One person said, "You can ask the cooks for anything. If they can get it, they will do it for you", and a second person commented, "Nothing is too much trouble for the cooks. I like the food." Relatives also gave us positive feedback about the food at the home. Comments included, "They always make sure that people get a birthday cake. They prepared us a lovely tea for [my relative's] birthday", "I know they are always asking people if they are happy with the food", and, "[My relative] would make it quite clear if [they] did not like the food."

During the inspection we observed breakfast, lunch and tea being served, and one member of the inspection team ate lunch with people using the service. We noted most people were not offered a choice of food or drinks at meal times. Only in one lounge area where a small group of people chose to spend most of their day, including meal times, were people asked if they were happy with the meal provided to them. We saw one person in this lounge request an alternative and received it. Other people were presented with their meal and a cold drink and given no option to request an alternative. We saw the menu board in the main dining area described one option for each meal, suggesting no choice was available. We also observed care staff putting aprons over people's heads in preparation for their meal without asking people if they wanted

them on first, and taking them off without communication after the meal.

Some people needed support from staff to eat and drink. Helping people at mealtimes is often a good opportunity for staff to spend one-to-one time with people and provide social interaction. We saw effective support was not always provided by staff. For example, two staff supporting two people to eat lunch were observed having a conversation about their personal lives while they assisted the people to eat. A third care worker got up four times to support other people whilst assisting a person to eat a dessert because no other staff were present. A fourth member of staff stopped assisting a person to eat halfway through a meal to put a CD on, because they thought the room was quiet. We also noted people being supported to eat were not always told what the meal they were eating was, and at no time during the inspection did we hear people being asked if they had eaten enough or whether they would like more food. Our observations showed staff became task-focused at mealtimes; this meant people were not offered choices and support provided was not always person-centred.

Lack of choice and person-centred care at mealtimes was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our observations to the registered manager. Two days after the inspection he sent us an action plan which included staff training and supervision on providing effective support at mealtimes; it was also an agenda item for the upcoming November 2017 staff meeting and he planned to audit the dining experience more closely.

The food and fluid intake of people deemed to be at nutrition and/or hydration risk at the home was monitored. On the second day of inspection we reviewed the food and fluid charts of four people for the previous day and found all four fluid totals for the day were poor. For example, one person was recorded as drinking 300ml and a second person 465ml. We also noted none of the four people were recorded as receiving any snacks at mid-morning, mid-afternoon, or at bed time, although we saw a trolley with drinks making mid-morning and mid-afternoon rounds. The registered manager told us he had oversight of people's daily records, including food and fluid charts, but could not explain the poor record-keeping or lack of action taken to address it. We also noted food charts did not record how much food was offered to each person, just whether they had consumed a quarter, half, three-quarters or all of their meals. At mealtimes we had observed significant differences in the portions people were offered; kitchen staff told us this was in accordance with people's preferences. This meant standard portions were not used, so food records of 'a quarter' or 'half' lacked meaning.

Various measures were in place to ensure the staff team at the home worked together to meet people's needs. The registered manager arrived for work early most weekday mornings to attend handover between the night and day staff. We arrived unannounced before 7am on the first day of this inspection and the registered manager was already at the home. He also told us this was so he was available to night staff should they wish to raise any issues or concerns with him. We saw there were notice boards in the care workers' staff room which showed which people needed specific types of support, for example, to reposition in bed or specially modified food or fluids. A system of staff rotation was in place, such that care workers worked across the different units, whereas the senior care workers stayed on the same unit each day, in order to provide continuity of care for people. This meant consideration had been given as to how to promote team-working to better meet people's needs.

People and their relatives told us people had access to a wide range of healthcare professionals to support their health needs. Records we saw supported this. Comments from people included, "I am seeing the doctor today. The manager arranged it", "I have my own optician. The staff make me an appointment when

the time comes around", and, "If you tell staff you are poorly they get the nurse or they call the doctor and they always let [my relative] know." Relatives gave us very good feedback about the communication they received from the home regarding the health of their family member who used the service. One relative said, "The staff call you if there's a problem, even for the smallest thing", and a second relative told us, "They call the opticians and chiropodist for [my relative]. They always let me know when they do it."

Healthcare professionals we contacted as part of this inspection told us referrals made to them by the home were appropriate and care staff followed advice given to them. One told us, "They will follow advice and feed back to me."

The registered manager told us over 90% of the people at Autumn House were registered with the same doctors' practice. GPs from the practice carried out rounds at the home once a week to review people and their medicines, and to see people staff had concerns about. The registered manager told us GPs would still come to the home at other times if they were needed, but the arrangement worked really well, and had reduced GP visits whilst ensuring people were reviewed by GPs regularly. The registered manager told us, "People's wellbeing is better managed due to better oversight by their GP." This meant people had access to healthcare professionals to meet their wider health needs and the home worked in partnership with GPs to ensure people's health needs were reviewed on a regular basis.

The home had been adapted to better suit the needs of people living with dementia. Floor coverings were plain to reduce visual confusion, word and picture signage was in place, and people were encouraged to bring their own furniture from home to personalise their rooms. A plan was in place to replace all handrails at the home with rails whose colour better contrasted with the wall colours so they would stand out more. The activities coordinator had secured a grant from the local mayor's fund to convert one part of a lounge area to a 1940s café, complete with a large photographic wall covering of a café, plus tables and chairs, and a display of 1940s food packaging for reminiscence sessions. The meant good practice in dementia-friendly environments had been used to adapt the building to better suit people's needs.

The registered manager also used evidence-based practice and nationally available guidance to underpin care and treatment practice at the home. Records showed staff had completed 'React to Red' training with a tissue viability nurse to better manage risk to people's skin integrity. Shortly before the inspection the registered manager had updated infection control audits using guidance from the Department of Health. Information relating to dementia care and good practice was available to relatives in the reception area of the home. In addition, a dementia training session open to all staff, people and relatives had been held at the home; records showed it was well-attended. This meant the service used good practice to ensure effective care and treatment was delivered in line with legislation and standards.

Requires Improvement

Is the service caring?

Our findings

People told us staff at Autumn House were caring, and their relatives agreed. One person said, "The staff are lovely and caring", and a second person told us, "The staff are so kind." Comments from relatives included, "Staff give excellent care", "Staff have so much care and compassion", and, "(Staff are) more than caring. Some will go the extra mile for you." Healthcare professionals we spoke with also described staff as caring. One told us, "I think staff are caring. It's a very homely atmosphere", and a second said, "There are some really good carers there that know the people well." People and their relatives also told us staff made visitors feel welcome. One relative said, "The staff are like family", and a second told us, "All the staff make you feel welcome."

As described earlier in this report, at mealtimes we observed staff became task-focused such that the support they provided to people was not always person-centred. When we arrived early on the first morning of inspection we noted at least nine people's bedroom doors were propped open whilst people were still in bed. This meant any staff or people passing in the corridor could see the room's occupant in bed. Staff told us doors were open so people's safety could be ensured but this requirement was not included in their care plans. This meant some people's dignity was compromised whilst they were in bed. After our discussion with the registered manager, all doors were closed and we saw they remained closed for the duration of the inspection.

Most other interactions we observed between staff and people were respectful and supportive. For example, we saw care workers asking people who needed continence support if they needed to use the toilet on a regular basis; this helped promote people's dignity. Care workers could describe how they promoted people's privacy and dignity in other ways, such as closing doors and curtains during personal care, and keeping people covered as much as possible during personal care. One person told us, "Staff will always knock and call out before they come in my room."

Care workers we spoke with could demonstrate an in-depth knowledge of people's like, dislikes, preferences and personal histories. This included using people's preferred mode of address which we saw was documented. During the inspection we observed warm and supportive interactions between staff and people, and heard laughter and banter exchanged.

People were encouraged to furnish their rooms with their own items when they moved in, and were also asked if they would like their rooms redecorating to suit their personal taste. The registered manager described how one person seemed unsettled and unhappy with their room when they first moved in, so staff had tried to rearrange their room to see if this would help. Eventually the registered manager told us they asked the person's relatives to describe the person's sitting room at home, including where their chair and TV were located. Staff then moved their furniture round to match and after this the person was much happier. This meant staff learned people's preferences to make them feel at home.

People told us staff helped them to remain independent. One person said, "I maintain my own independence, although staff support me with this", and a second person told us, "If it was not for this staff

team, I would not be as independent as I am." Relatives also told us staff helped their family members to remain independent. One relative said, "It was due to the staffs' efforts that [my relative] is walking today", and a second told us, "They always encourage [my relative] to be independent."

We asked people and their relatives if they were involved in planning people's care and reviewing their care plans regularly. Feedback was mixed. One person said, "I was involved in my care plan before I came to live here but not since." A relative told us, "[My relative] was fully involved in developing [their] care plan", a second relative said, "We have been to a review of [our relative's] care with [name] the (registered) manager", and a third relative commented, "We have not been invited to any reviews in a long time."

The registered manager told us people and their relatives were asked to develop care plans and review them regularly, but care files we saw did not evidence this. People deemed to lack mental capacity to take part in care planning had a form in their files to record if their relatives wanted to be involved in their care planning. On some of these forms, dates had been included to show when relatives who wanted to be involved had been asked to a review and whether they had attended, but the extent of their involvement or any outcomes were not recorded. There was no equivalent form for people with mental capacity to state how they wanted to be involved in planning their own care and if they wanted their relatives to be involved. At the inspection the registered manager told us he would develop a form to record people's wishes.

Two days after the inspection the registered manager sent us an action plan which stated people and their relatives (if relevant) would be asked to attend regular care planning reviews and in future their involvement, or refusal, would be recorded.

Some people used advocacy services to help support them with decision-making. Contact details for advocacy services were displayed at the home and included in service user handbooks. The registered manager could describe when and how to make referrals for advocacy support and gave examples of when he had done so for people at the home. This meant people had access to independent support with decision-making when they needed it.

We asked the registered manager how he promoted an open culture at the home which was inclusive of people's choices around equality, diversity and sexuality. He told us care workers received training on equality and diversity, and the home focused on providing person-centred care according to needs identified during the pre-assessment process prior to a person moving into the home. People with religious needs had seen church officials. Records kept by the activities coordinator evidenced people with mobility issues and/or more advanced dementia had equal access to trips and activities outside the home, which showed they were not discriminated against.

The registered manager explained that due to the demography of the surrounding area, the home had not had the opportunity to cater for any residents with non-Christian religious needs or diverse cultural needs not represented within the community presently served. However, he said the home would welcome any such person if they chose to come and live there. At times couples had been admitted to the home together; the registered manager told us they had all been given options over their bedroom and sleeping arrangements, including whether they wanted to share a room and/or a bed. We saw people's care files included a sexuality care plan which described each individual's personal style and how they liked to look. This meant the registered manager promoted an open culture which was respectful of people's equality and diversity needs.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt confident to report any concerns to the registered manager or to other staff, if they needed to. One person told us, "If ever you have a worry you can talk to [the registered manager] and he will sort it out straightaway", and a second person said, "You don't have to complain, as soon as you mention that there is a problem, they sort it out." Relatives we spoke with agreed. One relative told us, "The (registered) manager has made it clear that if we have any concerns we must tell him", and a second relative said, "If ever I have a problem I would go straight to [the registered manager]. I know he would listen."

No complaints had been received by the service from people or relatives since the change of registered provider in October 2016. Records showed on two occasions' information of concern had been received from other sources and the registered manager had treated these as complaints in accordance with the provider's complaints policy. The complaints policy was clearly displayed in the home's foyer and reception area. This meant the registered manager had fostered an open culture whereby people and relatives felt able to raise concerns if they needed to.

We found the quality of people's care plans varied. As discussed earlier in this report, some care plans lacked detail on how staff were to support people safely. We saw other good examples where people's personal histories and preferences had been used to personalise their care plans, particularly those pertaining to their sexuality, personal care and social activities. Other people's care plans lacked person-centred detail in relation to the support they needed to help manage their behaviours that may challenge others. For example, the care plan of one person who became distressed during personal care stated their behaviours had no triggers and contained only brief person-centred detail as to how to help calm and reassure the person. There was no requirement in the person's care plan for staff to complete antecedent, behaviour and consequence charts (ABCs) to try and understand the triggers for the person's behaviours and how best to calm them down, so that future episodes of distress could be minimised. The care plan for another person who experienced behaviours which may challenge others had a similar level of detail, and did not require staff to collect information on ABC charts. These were missed opportunities to better meet the people's needs.

People living with dementia did not have specific dementia care plans or information included in their other care plans as to how their dementia affected them. We raised concerns during the inspection about the lack of knowledge some care staff had about supporting people with dementia. We also observed examples of poor practice, particularly in the unit for people whose dementia was more advanced. One healthcare professional we spoke with as part of this inspection told us, "I feel the dementia side (higher dependency unit) is less personalised." Two days after the inspection the registered manager sent us an action plan which included staff supervision, refresher training and discussion of dementia care at the next staff meeting.

We saw evidence that people's care plans had been evaluated, reviewed and updated. However, at times this was done by crossing information out and adding notes, rather than re-writing the care plan to make it easier for staff to follow. For example, in one person's mobility care plan, the words 'fully mobile and

independent' had been crossed out, and the words 'bed bound' written above. This represented a significant change in the person's support needs and yet the care plan had not been re-written. The registered manager was aware of this issue and said measures were already in place to ensure care plans would be updated rather than amended in future.

During this inspection we observed staff were responsive to people's requests for support and could describe people's support needs, as well as their likes, dislikes and preferences. Staff told us they accessed people's care plans and attended 'handover' meetings, where updates' on people's health and welfare was provided at the start of each shift.

People gave us very positive feedback about the activities coordinator, and told us they had access to a wide range of activities inside and outside the home. One person said "We have some nice days; games outside, quizzes and celebrations", a second person told us, "[The activities coordinator] is great. [They do] lots of interesting things. I love the entertainment sessions, I love to dance. It's a good laugh", and a third person commented, "The activities are so important to me, they keep my brain cells active." People's relatives were also complimentary about the activities provision at Autumn House, and about the activities coordinator. Comments included, "[The activities coordinator] puts so much effort into making events fun and special", "[The activities coordinator] makes sure there is a range of activities every day", and, "[My relative] loves to get involved in any of the activities. [They] love the music sessions, [they] even enjoy a dance."

During the inspection we observed people were engaged in activities and the activities coordinator showed us photos of people participating in activities that had been arranged. These had included a beach-themed day in the summer which was inspired by one person who wanted to go to the seaside, but was unable to due to poor health. The home been decorated and people were served fish and chips outside. Records showed people had enjoyed the day. A weekly disco was held in the higher dependency unit which was open to all people at the home; this involved dancing and singing. The activities coordinator also arranged for people to go out shopping, and worked in partnership with a local supermarket, whose project officer offered activity opportunities to people in the home and at the store. The activities coordinator could describe the activity needs and preferences of people nursed in bed or who preferred to stay in their rooms, who they visited to provide person-centred interactions. This meant people had access to a range of activities which they enjoyed.

We asked relatives about end of life care at the home. One relative told us, "The doctor told us that [my relative] was very poorly and that [they] had started end of life care. The end of life care is excellent; our [relative] was in need of this. The care was fantastic." A second relative said, "We have had meetings with [the registered manager]. He has helped our family come to terms with [our relative's] deteriorating condition." Feedback we saw from a families whose relative had received end of life care at the home included, 'We realise just how lucky our [relative] was to spend [their] last [number] months being taken care of in the most attentive way by professionals', and, 'All staff were brilliant and gave extra special dignity and respect when it was most needed at the end of [our relative's] life.'

The registered manager told us staff were supported by GPs with end of life care for people with nursing needs, and by Macmillan and community nurses for people with residential care needs. These external health professionals provided end of life care plans for people's clinical needs; however, we found the service had not developed person-centred care plans which described how people wanted to be cared for as they approached the end of their lives. The end of life care plans we saw contained very little information. One care plan for a person with mental capacity included seeking and acting upon the person's family's wishes, but did not include seeking the wishes of the person. The registered manager agreed people's end of

life care plans could be improved and said people and relatives would be consulted as part of the updated care plan consultation process which was to be implemented.

One person was receiving end of life care during this inspection. We saw staff focused on providing care and support for the person, as well as for their relatives. Care staff had received training in end of life care and could describe what was important to people as they neared the end of their lives. We saw care workers providing end of life care were knowledgeable, and empathetic to people's needs.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they thought the home was well-managed and gave positive feedback about the registered manager. One person said, "The (registered) manager has worked so hard to make me feel at home", and a second person told us, "The manager and staff are approachable. There is nothing that [the registered manager] will not do for you." Comments from relatives included, "I have every confidence in how the home is managed", "[The registered manager] makes a big difference", and, "The home is very well-run. It's marvellous."

Records showed a range of monthly audits were in place for monitoring the safety and quality of the service. These included medicines, people's care files, infection control, health and safety, and people's dining experience. A mattress audit had been added to the monthly audit schedule in October 2017, which showed the registered manager sought to improve hygiene at the home. Meeting minutes evidenced the results of audits were discussed with the registered provider at a monthly meeting.

However, as discussed earlier in this report, at this inspection we identified concerns around medicines administration and recording, cleanliness at the home, the updating of care plans, the quality of information recorded on food and fluid charts, and a lack of choice for people at mealtimes. None of these issues had been identified by audit. We noted the registered provider did not conduct their own audits, although they had employed a consultant to conduct a Care Quality Commission style inspection in September 2017. The action plan from this inspection included issues we found at this inspection, for example, the lack of evidence relatives and friends had Lasting Power of Attorney, and a lack of person-centred approach in some care plans. This meant the registered manager and registered provider lacked oversight in some areas at the home and had failed to take action to resolve issues they had been made aware of.

This was a breach of Regulation 17 (1) and (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was responsive to our feedback. During the inspection he ordered two new shower chairs for delivery the same week. He also submitted an action plan two days after the inspection detailing how he intended to make improvements in the areas we had raised concerns.

The registered manager had more oversight of the day-to-day running of the home and could demonstrate a good knowledge of the care and support needs of each person using the service. He told us he attended GP rounds if the nurse on shift was too busy and made appointments for people with external healthcare professionals. He also worked as the nurse on duty one or two shifts every month to maintain his nursing competence. Feedback from external healthcare professionals about the registered manager and communication with the home was positive. Comments included, "He (the registered manager) knows about the clients", "I think he's really good. He can challenge us in a positive way if he has concerns about a resident", and, "He works well with us. He'll support us." As a result of recommendations from another external healthcare professional, the registered manager had been asked to show two other providers around the home, focusing on their dementia-friendly environments and activities for people living with

dementia. This meant the registered provider promoted partnership working at the home.

Records showed regular meetings were held for people and their relatives to feed back about the service. Agenda items had included food, staffing levels, activities, and any concerns people had. Minutes showed actions from the last meeting were reviewed and completed by the next meeting. People said of the meetings, "I got to all the meetings. It's where you can share your thoughts and ideas. This is how you get things changed", and, "The manager makes it clear that this is my home, so I must have a say in how it's run."

In addition to these monthly meetings, notices informed people and relatives of the registered manager's 'open door policy' which meant they could bring issues to him at any time. There was also an annual survey; we saw the results of the survey and action taken in response, was available for people and relatives to read. Feedback was also sought via a care home rating website; we saw the latest score published in March 2017 rated the home as 9.7 out of 10.

Feedback about the registered manager from staff was positive. Comments included, "I think [the registered manager's] brilliant, I feel very supported by him. If I had any concerns I'd definitely feel confident to raise them", and, "He's approachable but he's not soft." Staff attended regular team meetings; minutes showed they had discussed people's needs, staffing levels, fire safety, safeguarding and training. One member of staff explained how the change from two units to three units at the home ongoing at the time of this inspection was one of the care worker's ideas which the registered manager had actioned. This meant the registered manager encouraged a collaborative approach to decision-making at the home, which involved people, their relatives and staff.

The vision and values of the service were prominently displayed on a noticeboard at the home. Each value was explained with a statement about how it was used to underpin care at the home. Values included a person-centred approach, compassion, dignity and respect, and recognising people's individuality. The registered manager told us he promoted the values to staff at team meetings and in supervision sessions. One care worker we asked about their role told us their job was rewarding and fulfilling, and they enjoyed, "Giving something back." A second care worker said, "It's not like a job to me", and a third commented, "I love it here. The job has been my whole life. It's long hours and hard work, but I love to help people." Feedback from people and their relatives, and our own observations of care at the home showed us most staff understood the vision and values of the service and it underpinned the support they provided. However, as discussed earlier in this report, we saw person-centred support was not always provided at mealtimes and on the higher dependency unit for people with more advanced dementia, and this required improvement.

Under the regulations registered providers are required to report specific incidents to the Care Quality Commission. Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. Records we saw showed all such incidents had all been reported appropriately.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care at mealtimes was not always person-centred. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems in place were not always effective in identifying concerns and driving improvement. Regulation 17 (1) and (2) (a) (b) (c) (f)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We identified concerns around the administration and recording of medicines. Regulation 12 (1) and (2) (g) We raised concerns about cleanliness at the home. Action taken in response to our concerns was not effective. Regulation 12 (1) and (2) (h) People's care plans did not always contain the information staff needed to provide safe support. Staff did not always follow people's care plans and placed people at risk. Regulation 12 (1) and (2) (a) (b)

The enforcement action we took:

We served a Warning Notice on the registered provider and registered manager. They were told to be compliant with the regulation by 23 March 2018.