Autumn House Care Limited

Autumn House Residential Home

Inspection report

21-27 Avenue Road
Sandown
Isle of Wight
PO36 8BN

Tel: 01983402125

Date of inspection visit:
29 August 2019
30 August 2019

Date of publication:
25 September 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Autumn House is a residential care home providing personal care to 35 people aged 65 and over at the time of the inspection. Most people were living with dementia. The service can support up to 42 people.

The home is based on two floors with an interconnecting passenger lift. It is located in the heart of Sandown, close to local amenities.

People's experience of using this service and what we found
People's nutritional needs were met. However, the mealtime experience was not positive for people. Staff were rushed, noise levels were sometimes high and people were not supported to eat in a dignified way. We have made a recommendation about improving the mealtime experience for people.
At all other times, people were treated in a kind, calm and compassionate way by staff who were competent and understood their needs well.
Infection control risks were usually managed appropriately. Action was being taken to improve waste disposal facilities.
Recruitment practices were safe and there enough staff to meet people's needs. People were protected from avoidable harm and received their medicines as prescribed.
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 were supported to access health and social care professionals if needed.
People's care needs were met in a personalised way, in accordance with their individual needs.
People knew how to raise concerns and there was an accessible complaints policy in place.
People and relatives had confidence in the management and said they would recommend the home.
Managers understood their regulatory responsibilities.

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

Rating at last inspection
The last rating for this service was requires improvement (published in September 2018). The rating has improved to Good.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.
We have made a recommendation about improving the mealtime experience for people. We will follow this

up at the next planned inspection.

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 safe. Details are in our safe findings below.	**Good**
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 service was well-led. Details are in our Well-led findings below.	**Good**

Autumn House Residential Home

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We used all of this information to plan our inspection.

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

and made the judgements in this report.

During the inspection
During the inspection, we spoke with nine people living at the home and two visitors. We spoke with members of staff including the administrator, the kitchen manager, three housekeeping staff, a maintenance worker, six care workers, a duty manager, the head of care, the registered manager, the provider's compliance manager and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 due to cognitive impairment.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
After the inspection, we continued to seek clarification from the provider to validate evidence found. We also sought feedback from three professionals who regularly visit the service.

Good

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 improved to Good. This meant people were safe and protected from avoidable harm.

Preventing and controlling infection
• The home was clean, hygienic and well maintained. One person told us, "It's very clean here." Another person said, "The laundry is amazing, all my clothes are done really well and with care."
• Housekeepers completed regular cleaning, in accordance with set schedules.
• However, we noted that many of the bins, including clinical waste bins, did not have pedal-operated lids. This meant staff had to touch the lids to open them, which risked spreading infection. We discussed this with the registered manager, who acknowledged the issue and immediately ordered replacement, pedal-operated bins for all areas of the home.
• We also noted that two staff wore multiple rings on their fingers. These presented infection risks, as they could compromise hand hygiene, and had the potential to cause skin tears to people with frail skin. We discussed this with the registered manager who assured us they would address the issue immediately.
• Personal protective equipment (PPE), including disposable gloves and aprons were available throughout the home. In addition, people who used hoists had individual slings allocated to reduce the risk of cross infection.
• The laundry room was cramped and the provider was considering ways of improving the facility. However, it was tidy and organised, and staff operated an effective system to reduce the risk of cross-contamination between dirty linen awaiting washing and clean linen that had been washed.

Staffing and recruitment
• There were enough staff available to keep people safe and to meet their needs. All the people and relatives we spoke with told us they felt there were sufficient staff. Comments included: "There are always lots of staff around" and "They always come straight away night or day."
• Throughout the inspection, we observed that call bells were responded to quickly.
• Staffing levels were determined by the number of people using the service and the level of care they required. The management team regularly monitored the staffing levels by observing care and speaking with people and staff to ensure that staffing levels remained sufficient.
• The registered manager told us staffing levels were constantly reviewed. For example, they were in the process of adjusting the rota to provide more staff later in the morning, as they had noticed that people were increasingly choosing to get up later.
• People were supported by consistent staff. Short term staff absences were covered by existing staff members or a member of the management team; this helped ensure people received continuity of care.
• There were clear recruitment procedures in place. These included reference checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safe recruitment decisions.

Using medicines safely

• Arrangements were in place for obtaining, storing, administering, recording and disposing of medicines safely and in accordance with best practice guidance. One person told us, "I always get my pills on time."
• Staff had been trained to administer medicines and had been assessed as competent to do so safely. Medication administration records confirmed people had received all their medicines as prescribed.
• Special arrangements had been made to help ensure that one person, whose medicines were time-critical, received them promptly.
• For people who were prescribed medicines to be administered on an 'as required' (PRN) basis, there was clear guidance to help staff understand when to give them and in what dose.
• When PRN medicines were prescribed for anxiety or agitation, staff described other strategies they used to support the person first, before resorting to sedation. Records showed this was usually effective as PRN sedation had rarely been needed.
• There were effective systems in place to help ensure the application of topical medicines, such as creams was completed safely. The date creams had been opened was recorded, to help ensure they were not used beyond their 'use by' date.

Assessing risk, safety monitoring and management
• People were effectively protected from the risk of harm. Relevant risks had been assessed and recorded, along with action staff needed to take to mitigate the risk. For example, risk assessments were in place for people at risk of developing pressure injuries. Where pressure-relieving equipment was needed, this had been provided and staff monitored the integrity of people's skin closely.
• The risk of people falling was managed effectively. Staff followed a falls protocol; if a person sustained a head injury, staff sought medical advice and conducted observations for 24 hours afterwards to check for signs of brain injury. Following a fall, the person's falls risk assessment was reviewed and extra measures considered to reduce the risk of further falls.
• Other risk assessments in place included areas such as medicines management, behaviours, mobility, use of equipment, nutrition and the use of bed rails. Staff understood how to mitigate these risks.
• Staff also supported people who chose to take positive risks. For example, one person liked to move furniture around in their room; staff supported the person to do this, while monitoring discretely to make sure they did not inadvertently create trip hazards.
• Checks of the water quality and temperatures were conducted regularly and records confirmed they were within acceptable safety limits. Lifting equipment, such as hoists, were maintained according to a strict schedule. In addition, gas and electrical appliances were checked and serviced regularly.
• Wheelchairs and walking aids were kept in good working order. One person told us, "My [walking] frame broke last week but they mended it straight away."
• Fire safety risks had been assessed and fire detection systems were checked weekly. Personal emergency evacuation plans had been completed for each person, detailing action needed to support people to evacuate the building in an emergency. There was also a business continuity plan in place to deal with a range of foreseeable emergencies.

Systems and processes to safeguard people from the risk of abuse
• Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse. One staff member told us, "I will raise anything that's not right and will advise [the duty manager]."
• People said they felt safe living at Autumn House. For example, one person told us, "I'm safe and very happy here." A family member said, "We have every confidence the home is safe."
• We viewed examples of investigations conducted by managers following allegations of abuse. These had been conducted in liaison with the local safeguarding team and we saw appropriate action had been taken where needed.
• When people moved to the home, their valuables were photographed to safeguard them; this also helped staff identify and find them if they became lost. One person confirmed this and said, "My possessions are

safe."

Learning lessons when things go wrong
• The registered manager described how they constantly monitored incidents, accidents and events to identify any learning which may help keep people safe.
• This enabled any trends or themes to be identified, so action could be taken to mitigate the risk and prevent reoccurrence. For example, to help reduce the number of falls, the provider had arranged for all care staff to receive falls prevention training to aid their understanding of risk factors.
• Following a safeguarding investigation, the provider enhanced their whistle blowing procedures to provide more opportunities for staff to raise concerns if they were worried about people.

Requires Improvement

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. The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
• People received enough to eat and drink and told us they enjoyed their meals. One person said, "They know how to cook nicely. The food is good." A relative told us, "The food is excellent. I've had meals here too."
• However, we found the lunchtime meal was not organised in an effective way that made it a pleasurable experience, protected people's dignity or promoted good intake.
• The Alzheimer's Society states that a "relaxed, friendly atmosphere with soft music" may help encourage a good appetite, but we observed the opposite of this.
• There was only one sitting arranged at lunchtime for all 38 people living in the home. This was split between a main dining room and a "bistro dining room", where people needed a high level of support.
• On the first day of the inspection, we found noise and activity levels in both dining rooms were very high. Staff appeared under pressure and were rushing about, trying to ensure people remained seated, received their chosen meals and were supported where needed. In the bistro dining room, there was loud pop music playing which proved over-stimulating for some people, one of whom became agitated and had to leave.
• People did not always receive enough support to eat their meal whilst it was still hot; some people's meals had gone cold by the time they had been given sufficient support to finish them.
• A person in the main dining room was struggling to use their utensils. One staff member told the person to use their fork and placed it in their hand, before rushing off, followed almost immediately by another staff member who told the person to use their spoon instead. Neither staff member stayed long enough to check the person was managing.
• The person started using the wrong end of the spoon and scooped all of the meal into their lap, from where they tried to eat it with their fingers. The second staff member returned, scooped a spoonful of food from the person lap, and gave it to them to eat. This significantly compromised the person's dignity and most of their meal was lost. On the second day of the inspection, the person ate in the Bistro dining room, where they received a more appropriate level of support.
• People in the Bistro dining room were seated at tables of three, with a staff member allocated to each table. This staff member supported two people at a time by placing a spoonful of food in each person's mouth alternately, in succession. At times, they left both people with partly eaten meals, to prompt and support the third person at their table and to serve meals and drinks to other people; this showed a lack of respect for people's dignity. They also wiped people's mouths without changing their protective gloves, which posed a risk of cross infection.
• On the second day of the inspection, one person in the Bistro dining room was very sleepy and did not wish to eat, but was left at the table, with their meal in front of them, for over 45 minutes until others had finished

their meals. Their meal was then re-heated and they were then supported to eat on a one-to-one basis on their own.
• We also found meal choices were not always offered in a supportive way. People were asked to choose their meals a day in advance, with the help of picture-based menus; however, when the meal arrived, most had often forgotten what they had ordered. When the meals were served, some staff usually placed them in front of the person without explaining what the meal was or checking the person was still happy with their choice. Where people had capacity to ask for alternatives, we saw these were given, but where people lacked capacity, staff did not proactively offer alternatives in a way the person could understand.
• A staff member told us, "Mealtimes are hectic most of the time. People probably find it hard, I know I would."
• We discussed our concerns with the registered manager. They felt our observations were not typical of the service people usually experienced.

We recommend the provider seeks support from a reputable source to review mealtime arrangements and ensure the support people experience is in line with best practice guidance.

• Each person had a nutritional assessment to identify their dietary needs and preferences.
• Staff monitored people's weight and acted if people started to lose weight; for example, they referred people to GPs or specialists for advice and offered meals fortified with extra calories.
• People were frequently offered hot and cold drinks and snacks such as biscuits or fruit. A 'hydration' station had also been set up in one area to further encourage people to drink well. One person told us, "I can have tea any time I like. I just ask and they get it for me."

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.

• Where people did not have capacity to make decisions, staff had completed MCA assessments, consulted with those close to the person and made decisions in the best interests of the person.
• Where people had capacity to make decisions, we saw they had signed their care plans to indicate their agreement with the proposed care and support.
• A clear process was in place to verify that any lasting powers of attorney (LPAs) had been registered correctly and were lawful. An LPA is someone appointed in law to make decisions for a person who lack capacity.
• People's right to decline care was respected. Staff were clear about the need to seek verbal consent from people before providing care or support. A staff member told us, "If someone [declined support], I'd go away and try again in ten minutes or get another [staff member] to try."

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 found they were. DoLS authorisations had been made when needed. Where conditions had been attached to authorisations, these had been followed.
• However, when we spoke with staff, some did not know which people were subject to DoLS and were

unable to explain the purpose or significance of DoLS authorisations. This posed a risk that people not subject to DoLS might be deprived of their liberty unlawfully. We raised this with the registered manager who agreed to provide additional training about this for staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Comprehensive assessments were completed before people moved to the home. Care plans were then developed to include people's identified needs and the choices they had made about the care and support they wished to receive.
• With the exception of mealtime support for people, staff usually followed best practice, which led to good outcomes for people. For example, they used a recognised tools to assess choking risk and the risk of skin breakdown.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments. Their diverse needs were detailed in their care plans which included their needs in relation to culture, religion, diet and sexuality, including gender preferences for staff support. One person wanted to continue to attend church and we heard staff supporting them to make arrangements for this to happen.
• Staff had completed training in equality and diversity and told us they were committed to ensuring people's equality and diversity needs were met.
• Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed and movement-activated alarms, linked to the call bell system, were used to alert staff when people moved to unsafe positions.
• In addition, the provider had invested in an electronic care planning system. This was available to staff via hand-held devices, on which they recorded the care they provided at the time they delivered it. This helped ensure people's care records were accurate and up to date.

Staff support: induction, training, skills and experience
• People and family members told us staff were knowledgeable and competent. Comments included: "I couldn't find fault. All the care given here is great", "They all seem to be well trained" and "[My relative] has never looked better. She's really happy here".
• Staff completed a comprehensive range of training to meet people's needs, which was refreshed and updated regularly. In addition, the registered manager ran short training sessions each week to refresh staff knowledge about topical issues. Staff were also supported to gain vocational qualifications relevant to their role.
• New staff completed a programme of induction before being allowed to work on their own. This included a period of shadowing more experienced members of staff.
• Staff who were new to care were supported to complete training that followed the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.
• Staff told us they felt supported in their roles. Comments included: "[The registered manager] talks to us and is always available if you need to chat", "I feel very supported by [the registered manager]. Any issue, I know I can go into the office and talk to them" and "I really like [the registered manager]. I had trouble at home and found I could talk to her about it".
• Staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Yearly appraisals were also completed, to assess the performance of staff and any development needs.

Adapting service, design, decoration to meet people's needs
• Adaptations had been made to the home to meet the needs of people living there; for example, corridors had handrails fitted to provide extra support to people. People's bedroom doors were decorated with items relevant to the person to make it easier for people to find their own rooms. There were also large, well-place

signs throughout the building to help people and visitors find their way around.
• Bathroom and toilet doors were painted in a bright colour to make them more visible to people and toilet seats were also of a bright colour to make them easier for people to see.
• People also had access to a level garden with seating and tables which we saw people enjoying.
• There was a range of communal areas available to people, including a dining area, lounges and quite room which allowed people the choice and freedom to choose where they wished to spend their time. One person told us, "It's good to have a choice where to sit."
• The home was decorated with a range of themes and colours to help people differentiate one area of the home from another. Decorations were age appropriate, for example they included posters from films people were familiar with which staff used to promote conversations.
• There was a rolling maintenance programme in place to help ensure the building remained fit for purpose; for example, new flooring had been laid in some rooms and we saw the external fire escape was being refurbished during the inspection.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People and their relatives told us their health needs were met and, if they ever felt unwell, a GP would be called without delay. Comments included: "The doctor comes any time I need to see him" and "Any problems and they call the GP out to visit straight away".
• People were supported to access other healthcare services, including specialists, when needed and to participate in regular health checks. For example, people were supported to access the memory service, dentists, chiropodists, and opticians.
• Changes to people's health needs and any visits from healthcare professionals were documented in their care plans, together with any follow-up action required. This helped ensure a consistent and joined-up approach to meeting people's healthcare needs.
• A community nurse who was visiting the home told us, "They [staff] call us when they need to and follow our advice. They do a good job overall."
• If a person was admitted to hospital or moved to other services, staff ensured that key information about the person was sent with them. This helped ensure the person's needs were understood and they received continuity of care. Where possible, a member of staff would also accompany the person to hospital.

Good

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 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 spoke positively about staff, describing them as "kind" and "caring" and said staff treated them "like their family". Comments included: "The staff are very pleasant", "The staff are wonderful and they spoil me" and "I know all the staff and they are all kind and considerate to me and my relative".
• Family members echoed these comments and told us they felt staff "really cared" about their relatives. A healthcare professional who had regular contact with the home said of the staff, "They are caring and compassionate; I don't worry about that."
• A recent thank-you card from a relative included the comment, "Your little team are exceptional carers who give their all with compassion and kindness."
• We observed positive interactions between people and staff. Staff were friendly, engaged in appropriate banter with people and approached them with respect. Whenever they spoke about people, they did so in an affectionate, caring way.
• With the exception of mealtimes (which we have described in the Effective section of this report), staff supported people in a calm, unhurried way. They also used touch, appropriately, to reassure people when they became anxious. When supporting people to use the hoist, they explained what was happening and providing verbal assurance throughout.
• During discussions with staff, they demonstrated a good understanding of people's individual needs, preferences, backgrounds and interests. They used this knowledge to engage with people in a meaningful way.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessments. Staff recognised people's diverse needs and respected their individual lifestyle choices. There were policies in place that supported this practice.

Supporting people to express their views and be involved in making decisions about their care
• People were involved in discussing and planning the support they received. One person told us, "I'm involved in care planning at every stage."
• The home operated a key worker system. A key worker is a named staff member who takes a particular interest in getting to know the person and acting as a point of contact with the family. One person told us, "I've really clicked with [my key worker], she's very jokey."
• Records confirmed that people had regular meetings with their key workers to discuss their views and make decisions about the care they received; these included decisions about their choice of activities and how they wished to be supported.
• We heard people being consulted throughout the inspection about where they wished to go and what they

wished to do.
• Staff ensured that family members and others who were important to the person were kept updated with any changes to the person's care or health needs.

Respecting and promoting people's privacy, dignity and independence
• With the exception of mealtimes (which we have described in the Effective section of this report), we found people were treated with dignity and respect.
• Staff described how they protected people's privacy during personal care. This included listening to people, respecting their choices and closing doors and curtains. We saw people were asked discreetly if they needed help with anything, including using the bathroom.
• People told us staff always knocked before entering their rooms and we observed staff knocking on bathroom doors before entering.
• Care records were kept securely. Information on the computer was password protected and restricted to those who needed to view it.
• A treatment room had been provided to allow healthcare professionals to examine and consult with people in private.
• Staff promoted people's independence. For example, one person told us they were free to go out without restriction, but staff had suggested they informed them before going out and carried identification in case they became unwell. This gave the person a level of protection without restricting their freedom.
• Care plans also encouraged staff to promote independence; for example, one said, "Encourage [the person] to clean his own teeth, just prepare the brush for him."

Good

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 Good. At this inspection this key question remained the same. 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 told us their needs were met and this was confirmed by family members. Comments included: "They know how I like things done" and "I don't need much help, but they [staff] let me do things my own way".

• Care plans had been developed for each person and provided sufficient information to enable staff to support people in a personalised way. These were updated monthly or when people's needs changed and included a discussion between the person and their key worker.

• Staff understood people's needs, wishes and preferences and could explain them to us. For example, they knew how to support a person with complex needs who could behave in a way that put themselves and others at risk. The person was resistant to receiving personal care, but staff had developed effective strategies to achieve this, including supporting the person with their catheter. A catheter is a tube inserted into the person's bladder that drains into an external bag.

• A staff member told us, "Everyone is different, for example everyone likes to wash in different ways." They then described how specific people liked to be supported to wash.

• Staff responded promptly to people's needs. We did not observe anyone having to ask more than once for assistance and staff willingly responded to both verbal and non-verbal communication from people.

• People were empowered to make their own decisions and choices and people confirmed they could make choices in relation to their day to day lives. For example, what time they liked to get up or go to bed, what they ate and where they spent their time in the home. Comments from people included: "I can do what I like and staff always help me" and "They [staff] let me make my own choice about things at all times".

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.

• People's communication needs were identified, recorded and highlighted in their care plans. This helped ensure that staff were aware of the best way to communicate with people, including those who had lost the ability to communicate verbally.

• Information could be given to people in a variety of formats; for example, easy read, large print and pictorial. Staff also had access to flash cards containing large writing and pictures to help them communicate with people.

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 had access to a range of activities that encouraged social inclusion. These included chair exercises, arts and crafts, bingo, music and quizzes and visiting animals. Themed days, such as for Valentine's Day and Halloween were also organised. One person told us, "I have a choice in what I do and can please myself if I want to join in."
• Some activities had been tailored to people's individual interests. For example, some people used to knit, so a 'knit and natter' group had been set up to promote knitting in a social group.
• As well as planned activities, staff also organised spontaneous activities during the day, such as games and reminiscence talks. We saw these were well received during the inspection.
• In addition, most staff had been trained in a touch-based therapy designed for people living with advanced dementia. It's aim was to create a calm, sensory experience for people. The home also had as a dedicated massage room and beauty therapist who visited twice a week.
• Special occasions, such as people's birthdays and anniversaries were celebrated and people were encouraged to invite family members to join them. One person described the atmosphere at Autumn House as "a community, a proper home".

End of life care and support
• At the time of the inspection, no one at the home was receiving end of life care.
• However, most staff had experience of supporting people at the end of their lives and had received training in end of life care, including at a local hospice. They described key aspects of end of life care, including comfort, symptom control, mouth care and support for the family.
• Links had been developed with community nurses and palliative care services to enable staff to seek specialist advice and support if needed.
• Staff were in the process of gathering and recording information about people's end of life wishes to help ensure they would be known and met when needed.

Improving care quality in response to complaints or concerns
• There was an accessible complaints procedure in place and people told us they would feel happy raising concerns.
• Records of complaints showed they had been investigated and dealt with thoroughly, promptly and in accordance with the provider's policy.
• The registered manager described how they used learning from complaints to help drive improvement and gave examples of when they had done so.

Good

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.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

- There was a clear management structure in place, which had recently been enhanced to provide more resilience. It consisted of the provider, the registered manager, the deputy manager, the head of care, the duty manager and the compliance manager. Each had clear roles and responsibilities.
- Managers told us they felt supported by the provider's nominated individual, who visited often. One manager told us, "No idea is ever dismissed." Monthly meetings were also held with managers to discuss relevant issues and monitor the progress of the action plan.
- Staff understood their roles and were provided with clear guidance of what was expected of them. Staff communicated well between themselves, for example during handover meetings, to help ensure people's needs were met.
- The provider's quality assurance system comprised of a wide range of audits, some of which had been effective in bringing about improvement.
- However, the audits had not picked up the concerns we identified with people's mealtime experience and the infection control issues. You can find more information about this in the Safe and Effective sections of this report.
- The provider's compliance manager acknowledged the need for more robust audit tools to pick up such issues and told us they were in the process of developing these with the support of staff from the local authority's quality improvement team.
- Where improvement actions had been identified, we saw they were monitored using a rolling action plan with completion dates and details of the person responsible for completing them.
- To monitor staff practice, managers conducted observational spot checks to assess the quality of care being delivered by staff. Staff told us the checks were done in a supportive and helpful way.

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

- People and their relatives spoke positively about the management of the service and told us they would recommend the home to others. Comments included: "Staff and management are all brilliant" and "It's a really well managed home".
- The provider had clear expectations about the values staff should work to and these were set out during their induction. These included taking responsibility, supporting people to achieve their goals, adopting a

positive attitude, and providing support and constructive feedback to colleagues. These values were communicated to staff at recruitment, during one-to-one conversation with managers and during staff meetings.
• From our discussions with staff, it was clear they understood these values and were committed to meeting them on their day to day work.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider consulted people in a range of ways. These included quality assurance surveys, 'residents' meetings' and one-to-one discussions with people and their families. The registered manager acted on people's feedback; for example, in response to feedback from a family member, they had ensured notice boards were more informative so relatives could better plan their visits. Menus had also been changed, based on people's feedback.
• Visitors told us they were always made to feel comfortable and were offered drinks. One visitor told us, "I can visit 24/7, 356 days a year. We are all made very welcome." A thank-you from a relative included the comment, "I have always been greeted with a smile and have been made to feel welcome."
• Staff told us they felt engaged in the way the service was run and that morale was good. They said they enjoyed a good working relationship with their colleagues and felt they worked well as a team.
• Staff spoke positively about the registered manager, describing them as "approachable" and "supportive". Other comments included: "I like working here, I feel appreciated", "I love the residents, staff are really nice, we all get on well", and "The managers are always here if I need them. They always understand, I do feel listened to".

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 registered manager was aware of their responsibilities under the duty of candour, which is a requirement of providers to be open and transparent if things go wrong. They provided examples of when this had been followed, both verbally and in writing, as required.
• The provider had prominently displayed the home's previous rating in the entrance lobby and on their website. The registered manager notified CQC of all significant incidents, in line with the requirements of their registration.
• All staff were open and transparent during the inspection and managers were responsive to suggestions for improvement.

Continuous learning and improving care
• The compliance manager gave examples of how they had used the previous CQC report and reports for other services to identify and drive improvement at Autumn House.
• The provider had engaged with the local authority quality improvement team, who had recently conducted a visit. The registered manager was working through the recommendations they had made for improvement.
• Plans were in place to enhance the service by introducing staff 'champions' to take the lead on aspects of people's care, including dementia, dignity, end of life.
• The provider was introducing 'pocket charts' which would provide a short summary of each person and their preferences; this would give staff ready-access to key information to help them understand people's needs better.

Working in partnership with others
• The service worked in collaboration with all relevant agencies, including health and social care professionals.

• The managers belonged to a local care homes forum, where they could seek advice and support from other care home managers. They had also attended an extended course funded by the local authority, aimed at improving overall standards in care homes.
• Staff had developed links with advocacy services to support people who did not have relatives to act for them. An advocate is an independent person whose role is to befriend people and help them express their views.
• Other links had been developed with community groups, including a scout group, whose children visited to engage with people and help with activities.