The Orders Of St. John Care Trust

OSJCT Athelstan House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
OSJCT Athelstan House is a large nursing home in Malmesbury for up to 80 people. Accommodation is provided over two levels accessed by stairs and a lift. People have their own rooms and en-suite bathrooms. People also have access to communal areas such as lounges, dining rooms and gardens accessed from the ground floor. At the time of our inspection there were 72 people living at and using the service.

People's experience of using this service and what we found
Since the last inspection there had been changes in management which had been unsettling for people and staff. There was now a registered manager in post who had worked for the provider for some years. Feedback about their approach was positive, staff told us they were approachable and "hands on" at the home.

Quality monitoring was not effective in all areas. The shortfalls we found had not been identified and action was not taken where needed. Systems were not robust in identifying areas of improvement which meant this service was rated requires improvement for the fifth consecutive inspection.

People had not always received their medicines as prescribed. There had been high numbers of medicines errors and incidents prior to our inspection, action taken in response was not always effective in preventing reoccurrence.

Risks to people's safety had not always been managed safely as guidance to manage the risks was not in place or was not being followed. Whilst people's needs had been assessed prior to admission, some guidance was not available for staff to follow. People were able to see a GP as they visited the home regularly. We found two referrals to healthcare professionals that needed to be made in a more timely way. Staff took action during our inspection.

People and staff told us there were not enough staff at times which meant people had to wait for a staff response. We have made a recommendation about staffing. Staff had been recruited safely and provided with an induction when they started work. Training was provided to staff when required and staff could ask for more training if needed. Staff told us they had supervisions and felt supported in their roles.

Not all the staff we spoke with understood what safeguarding and whistleblowing was and what action to take if they had concerns. We have made a recommendation about safeguarding training.

The home was clean, but we did see some cobwebs in high areas and raised this with the registered manager. Staff were seen to be wearing safe personal protective equipment (PPE) and staff told us they had guidance on how to use PPE safely. Government guidance regarding testing for COVID-19 was being followed and action taken where needed for any positive test.

Mealtimes were not rushed and people told us the food was good. We saw people had access to snacks and drinks throughout the day. We observed some mealtime support was not person-centred which we shared with the registered manager.

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 told us the staff were caring and worked hard. Staff told us they enjoyed working at the home and they all felt there was good teamwork. People had been asked for their views and results had been collected. The registered manager planned to discuss results with people at a 'residents meeting' which were held regularly.

The service had a group of volunteers who visited regularly to help with activities and maintaining the garden. Staff told us they wanted to start linking up with the local community again which the service had done prior to COVID-19.

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 10 November 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
We received concerns in relation to the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of the full report.

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for OSJCT Athelstan House on our website at www.cqc.org.uk.

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

We have identified breaches in relation to person-centred care and good governance at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

OSJCT Athelstan House

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by four inspectors, a medicines inspector and an assistant inspector.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 14 people and five relatives about their experiences of care received. We also spoke with 23 members of staff, the registered manager and area operations manager. We contacted three healthcare professionals for their feedback about the service and spoke with one of them on the telephone.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed 15 people's care and support records, multiple medication records, health and safety records and service certificates, incident and accident forms, staff rotas, four staff files for recruitment and risk monitoring records.

After the inspection
We continued to validate evidence found and we reviewed training data, health and safety data, quality monitoring records, medicines incidents data and analysis, meeting minutes and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

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

Using medicines safely; Learning lessons when things go wrong

- People had not always received their medicines as prescribed. The provider had identified prior to our inspection that medicine management required improvement. They were reviewing all areas of medicines management to continue to identify and carry out improvements needed. Whilst there was no serious harm to people observed, people had at times received more or less of their prescribed dose of medicines.
- In response to these incidents, staff involved were re-trained and re-assessed for their competence, however this course of action had not reduced the numbers of incidents seen. More time was needed before we could judge the provider's actions to be effective in ensuring their medicine policy was adhered to.
- During our inspection we reviewed people's medicines administration records. The required details were recorded and there were no gaps in recording. Where needed 'as required' protocols were in place to give staff guidance for this type of medicine.
- Medicines were stored safely, and staff checked the temperatures of medicines storage. Records seen demonstrate medicines were being stored within a safe range.

Assessing risk, safety monitoring and management

- At our last inspection we were not assured by action taken following two people leaving the building without staff knowing. Since that inspection, one person had left the building without staff knowing. This was due to a door lock failure. The person was found nearby and was not harmed, and action was taken to fix the door and make sure other people were safe.
- We were given assurance, in response to the incident, staff now did a welfare check and head count at each shift handover. This was twice per day. However, we found welfare check records for one area of the home had gaps in recording. For example, on two dates in July, staff had not recorded a welfare check and head count had not taken place for two mornings. This meant the provider could not be assured the system they had put in place to reduce the risk of people leaving the service undetected had been effective.
- Other risks to people's safety were not being managed following guidance in people's plans or there was no guidance in place for staff to follow. Examples included one person at risk of self-harm was not being monitored following the guidance in their risk management plan. Another person with a catheter had no guidance in place for staff to follow. We raised these shortfalls during the inspection with management.

Systems had failed to identify, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Systems were not robust in response to allegations of alleged abuse. We found a number of incidents of safeguarding that had not been reported to the local authority in a timely way. This included medicines incidents, allegations of financial abuse and one allegation of physical abuse between people living at the home. The provider took action during our inspection to refer incidents to the local teams and to submit notifications to CQC.
● Staff had been provided with safeguarding training however, not all of the staff we spoke with understood what safeguarding was or how this applied to their roles. This included the process of whistleblowing which is reporting any incidents of wrongdoing in the workplace. The registered manager told us they were reviewing training provision for some staff as this concern had been identified.

We recommend the provider reviews safeguarding training provided to staff to make sure they are assured staff understand systems and processes.

● We observed a television screen in the foyer which had information on safeguarding and whistleblowing on a presentation loop. This information was available to view for anyone in this area.
● Despite the shortfalls people and relatives told us people were safe at the service. Comments included, "It's good here, I feel safe and looked after" and "Yes I feel safe, the carers are helpful and kind."

Staffing and recruitment
● People and staff told us at times there were not enough staff. Comments included, "I'd give them nine out of ten here, the staff are great, but I think they are always short staffed and busy. They have agency staff to fill in and they are okay usually", "We could always do with more staff, I have to wait sometimes but I am used to it, can be frustrating" and "There are definitely not enough staff."
● Short notice staff sickness caused delays in covering gaps in rotas. Management tried to get agency staff cover and used agency staff to cover planned absence. However, at short notice it was not always possible to get agency to cover shifts.
● The registered manager told us the home tried to move staff around when there were gaps in rotas. Staff from different departments could help, and there were ancillary staff who could also be called on to support where needed.
● There was management cover provided over seven days which meant managers were in the building to help out where needed.
● The registered manager carried out a feeling safe survey prior to our inspection. People shared feedback that staff answered their call bells quickly enough. However, some people said staff did not.

We recommend the provider reviews how staffing decisions are made to include seeking and listening to people's experiences of care, and feedback from staff to help them determine the levels of staff needed.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Whilst the home was clean overall, there were areas where cobwebs were forming due to a lack of high dusting. We shared our findings with the registered manager who told us they would deal with this shortfall.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People could have visitors when they wished. We observed visitors in the home during the inspection and we were told there were no restrictions.

Good

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 our last inspection we rated this key question requires improvement. At this inspection the rating has improved to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were assessed prior to admission. This covered a range of areas including mobility which helped staff to know if they could meet people's needs.
- The service used nationally recognised tools such as a 'Waterlow' to assess people's risks of developing pressure ulcers. Where people were assessed as being at high risk staff had measures in place to reduce the risks such as special mattresses or cushions.
- People's oral health needs had been assessed which provided staff with guidance on how to support people's oral care. This included whether people needed support to visit a dentist.

Supporting people to eat and drink enough to maintain a balanced diet
- People told us they enjoyed the food and there was enough of it. Comments from people about the food included, "The food is excellent", "Food is very nice but could do with more choice of puddings" and "Food is good, I have a choice and there is plenty of it."
- People had access to snacks and drinks in-between mealtimes and we observed people had fresh drinks available in their rooms. People who were at risk of malnutrition had been assessed and staff were monitoring their weights.
- We did observe some examples of care that was not person-centred during mealtimes in one household. We have reported on this in the well-led section of the report. Mealtimes were not rushed, and we observed the food looked appetising.

Staff support: induction, training, skills and experience
- Staff told us they felt they received enough training for their roles. New staff received an induction which included completion of the Care Certificate.
- The provider had introduced a new role for supporting staff through their induction. An induction support coordinator was employed to be a link for staff to contact if they needed support or guidance.
- Training was provided in a variety of areas. Staff told us they had training by e-learning and face to face for some topics such as moving and handling.
- Staff were provided with the opportunity to meet with supervisors and talk about training needs. Staff were also supported to develop skills by completing work-based qualifications.
- The provider had developed leadership training for senior staff at the service. Staff had been positive about this training, so the provider rolled this out across their other services in the local area.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care

● We found two examples of people who had not been referred to healthcare professionals in a timely way. We raised this with the registered manager who told us they would take action without delay.

● People were able to see a GP when needed. GP's visited the home every week as their surgery was next door to the home. During our inspection we observed healthcare professionals at the home visiting people to review health needs.

● Staff were aware of specialist support available such as speech and language therapists and mental health professionals. The provider employed Admiral nurses who are dementia specialist nurses. Staff had contacted Admiral nurses for advice and guidance on supporting people living with dementia.

● Staff had handovers at the start of their shifts and used handover records to record changes in people's needs. There was a daily head of department meetings to discuss events, accidents and new admissions. This information was cascaded to other members of the team.

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

● The home was purpose built and divided into four households. Each household had its own communal areas for people to use such as dining rooms and lounge areas. There was a nursing unit on the ground floor and a dementia household with its own patio and garden area.

● People were able to bring in their own small pieces of furniture if they wished and put up pictures and photographs.

● Signage was available throughout the home to guide people to rooms such as dining rooms and bathrooms. We did find one bathroom which was being used for storing furniture and no longer used as a bathroom. We brought this to the attention of the area operations manager who took action to remove the bathroom sign from the door.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff had been provided with training on the MCA and those we spoke with knew about the principles of the MCA and how it applied to their work.

● Where people lacked capacity to make decisions this was assessed, and best interest processes followed.

● DoLS authorisations were applied for where appropriate and the local authority had been and reviewed some applications. For those authorised there were no conditions attached.

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At our last inspection we found management at the home had been inconsistent as there had been changes of home manager. Since that inspection, there had continued to be changes in home manager.
- At this inspection there was a new manager in post who had been full time at the home shortly before our inspection. They had worked for the provider for many years and were familiar with the providers policies and procedures.
- The area operations manager told us they had been supporting the home in the registered manager's absence, with the support of a head nurse and two deputy managers.
- At our last inspection we found quality monitoring needed improvement as it was not consistent across the home. We found records in one part of the home were not completed fully compared to another part of the home where records were complete. At this inspection, we found quality monitoring continued to be inconsistently identifying improvement needed.
- Systems were not always robust or effective in identifying and driving improvement. For example, we found medicines audits had been completed by night staff using out of date quality tools. More recent quality tools prompted staff to check if medicines incidents had been reported to the local authority. At this inspection we found medicines incidents that had not been reported which might have been identified if staff used the correct quality tool.
- Measures put in place to reduce the risk of administration errors were not always effective . For example, staff put up signs informing people a medicines round was in progress. However, staff told us these measures might work for visitors but did not work for people living in the home. Staff told us they were frequently distracted during medicines rounds to respond to people; this increased the risk of errors occurring. One member of staff told us they had to, "stop to feed people in the morning during the medicine round."
- Action taken in response to incidents and accidents was not always recorded comprehensively and incidents were not always referred to safeguarding teams and notified to CQC as required. Whilst the provider took action during the inspection to submit notifications, the providers quality monitoring systems had failed to identify this shortfall.
- Action had not always been taken to address improvements needed with some aspects of the property. This included action raised as urgent by external contractors. The provider addressed this during our inspection but their quality monitoring systems had failed to identify improvement actions had not been completed.

● This was the fifth consecutive rating of requires improvement for this service. The providers quality monitoring systems and processes had failed to identify action and ways of working needed to achieve a good rating.

Systems and processes were not established effectively to assess, monitor and improve the quality and safety and to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This placed people at risk of harm and was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We observed there were times in the dementia household when people's care and support was not person-centred. For example, during a mealtime one person was asked what they wanted to drink. They told the member of staff they wanted a cup of tea. They were given a glass of juice and did not have a cup of tea at all during the mealtime. Other people were given juice without being offered a choice.

● We observed two people who were asked by staff if they wanted their nails manicured. The people said that they would really enjoy this activity. Staff told them they would be back in two minutes to do this with them. We observed the people for a further 20 minutes, staff did not return. We checked later in the day to see if their nails had been manicured, they had not.

● We saw staff place clothes protectors on people without explaining what they were doing. One person told the staff they did not like the clothes protector. Staff continued to put it on the person.

● The registered manager told us they were taking responsibility for overseeing the dementia household. They told us they had carried out observations in other part of the home and would do so in the dementia household to identify care that was not person-centred.

● In another area of the home one person was calling for help for most of the day of our site visit. There was no guidance in their care plan for staff to know and understand why they might be calling for help. We raised this with the area operations manager.

● We also found other examples where people did not have all their care plans in place., such as in relation to the support they needed when in pain. This meant staff did not know what their individual needs were or how they were to be met.

People were not planned and provided with appropriate, person-centred care that met their needs. This placed people at risk of harm and was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were being cared for by staff who enjoyed their job and told us there was good teamwork at the home. Comments from staff included, "I like the working environment and I have supportive colleagues to work with" and "I absolutely love my job, I think it is the people I work with, the people I care for, they are so interesting, you learn so much from them."

● People told us whilst they thought staff were busy, staff were caring and tried their best. Comments from people included, "Staff are lovely, just not enough of them of course" and "The staff are kind and I get on well with them."

● Feedback about the new manager from the staff was positive. Comments included, "I have seen many managers. We have had some shocking managers, but the management team we have at the moment has given us some confidence for the first time in a long time" and "[registered manager] seems alright, he has made himself known and he chats with residents. He is approachable and he is quick to praise us. It is all positive so far."

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 provider had a duty of candour policy and the registered manager was aware of the requirement to be open and honest with people and relatives when things went wrong.

● The registered manager had written to relatives informing them of medicines errors at the home and apologised for getting people's medicines wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were asked for their views using surveys and meetings. The provider had recently carried out a survey focusing on 'safe'. Results of the survey were going to be shared with people at the next 'residents meeting'. Most people told the provider they felt safe at the home.

● Food surveys were used to gather people's views on food, these were analysed by the kitchen staff to help make improvements.

● Staff had opportunity to raise issues or discuss ideas at staff meetings. Minutes of the meetings were kept, enabling staff who could not attend to read what was discussed.

● The provider was carrying out a staff survey across all their services in Wiltshire. Due to the low response rate the provider had extended the timeframe for staff to share their views. This was open and ongoing during our inspection.

Working in partnership with others

● Staff worked in partnership with a range of healthcare professionals. There was a GP surgery and pharmacy on the same site as the home. GP's from the surgery visited the home regularly.

● We observed in people's notes other professionals involved in people's care such as community nurses, speech and language therapists and dementia specialists. Referrals to professionals and follow up communication had not always been timely. We shared this with the provider.

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 The provider had failed to make sure people had appropriate care that met people's needs and preferences. Regulation 9 (1) (2) (3)

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 17 HSCA RA Regulations 2014 Good governance Systems were not established to assess, monitor and improve the quality and safety of the service, and to assess, monitor and mitigate the risks relating to health, safety and welfare of people. The provider failed to maintain a complete and accurate record for people. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

We issued a Warning Notice.