The Orders Of St. John Care Trust

OSJCT Rodley House

Inspection report

Harrison Way
Lydney
Gloucestershire
GL15 5BB

Tel: 01594842778
Website: www.osjct.co.uk

Date of inspection visit:
11 June 2019
12 June 2019

Date of publication:
17 October 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
OSJCT Rodley House (known to people as Rodley House) is a residential care home providing personal and nursing care to 43 people aged 65 and over. At the time of the inspection 34 people lived at the home.

People lived in one adapted building which provided them with single bedrooms, bathing facilities and communal rooms to socialise in. People had access to a garden and there was car parking on site.

People's experience of using this service and what we found
The registered manager and deputy manager had been working in the home for just over two months at the time of the inspection, so there had been a recent change in the management of the service. Both managers were experienced in managing and supporting adult social care services. In that time, they had worked with the provider to make changes to how the service ran to secure better outcomes for people. The home manager had subsequently registered with the Care Quality Commission (CQC) and become the registered manager of the service.

Changes had been made to staff routines, roles and responsibilities so that a more person-centred approach to people's care could be adopted. People told us they felt well cared for by the staff who were kind and friendly towards them and who listened to them. Staff we spoke with felt positive about the changes taking place.

People, relatives and staff had been given opportunities to feedback their views and to make suggestions. Managers were listening to the feedback and suggestions they received when making changes to the service.

An on-going improvement plan was in place and some actions from this had already been met; others were making good progress. Observations were made during the inspection of people's care, their behaviours and how staff responded to people's needs. Subsequent information, provided by the provider, helped to put some context to the observations made during the inspection and demonstrated that staff took action to meet people's needs as well as their preferences.

Safe staffing numbers were maintained, and new staff had either already been recruited or were in the process of being recruited; a new chef and activities co-ordinator. The registered manager said, "It's about having the right staff, in the right place, at the right time and working in the right way." People were supported to take part in social activities which they enjoyed and which they had helped to choose.

A recruitment campaign was in place for more permanent nurses, but arrangements were in place with agency nurses to ensure people's health needs were consistently and competently met.

People's care plans gave staff guidance on how to meet people's needs. A plan was in place to further

personalise people's care plans to ensure these fully captured people's preferences, choices and wishes. Care plans which related to higher areas of risk and more complex care had been well maintained, this included wound assessments and care plans.

A robust staff handover system was in place to ensure staff received verbal guidance and updates relating to people's health and care needs. The deputy manager's role included working with staff, they and the nurses were available to provide support and advice to staff about people's care.

People had access to healthcare support and a more proactive and collaborative approach between professionals and the home was being sought to provide people with better support in relation to their health needs.

People's health risks and care needs were assessed, and action taken to reduce risks to people. There were good arrangements in place for the ongoing monitoring and management of potential risks, including those related to wound management and health related infection. People's medicines were managed safely. People's nutritional risks were monitored and addressed. Potential environmental risks associated with the building, equipment or spread of infection were identified and action taken to reduce or mitigate these.

Staff received on-going training relevant to their roles, so they had the knowledge to work safely. Staff were being supported to acquire new skills and knowledge.

People were supported to make decisions about their care and treatment and were supported in the least restrictive way possible. The policies and systems in the service supported this practice. The principles of the Mental Capacity Act and Deprivation of Liberty Safeguards were met.

People's privacy and dignity was maintained and people were supported to be independent.

Relatives were made welcome and one relative confirmed they were kept well informed about their relative's progress. They said, "It feels like a real partnership."

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 Good (published 14 December 2016).

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for OSJCT Rodley House on our website at www.cqc.org.uk.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

OSJCT Rodley House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
One inspector and an Expert by Experience carried out this inspection. 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
OSJCT Rodley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. However, the manager had applied to the CQC to be registered and was subsequently successfully registered. When registered 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.
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. This included previous inspection reports and details about incidents the provider must notify us about, such as abuse, serious injuries and deaths. We used information the provider sent us in their Provider Information Return as part of our Provider Information Collection. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with nine people who used the service and three relatives to gain their views of the services provided. We spoke with seven staff which included a representative of the provider, the home manager (subsequently registered manager), deputy manager, a nurse, two care staff and a member of the housekeeping team. We also spoke with one of the provider's visiting admiral nurses. Admiral nurses are expert practitioners in supporting people who live with dementia and those who look after them.

We reviewed a range of records which included four people's care files and records relating to the Mental Capacity Act 2005. We reviewed two people's medicine administration records. We also looked at two staff recruitment files and the main staff training record. We reviewed a selection of audits completed by staff, the last provider audit and the home's ongoing improvement plan.

After the inspection
We continued to seek clarification from the new managers to validate evidence we found in relation to water safety and improvements in relation to fire safety and evacuation arrangements, one person's care plan and medicine administration monitoring.

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 Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Staffing and recruitment
• Feedback we received from people and relatives was, staff were very busy, and they felt there were not enough of them to meet people's needs in a timely manner. We were also told that call bell response times had not been good with people waiting for their call bells to be responded to.
• Prior to the inspection and when managers had started in post the staffing numbers had been reviewed and managers confirmed during the inspection there were enough care staff in number to meet people's needs in a safe and timely way.
• Managers had however, identified that the hours and shifts worked by staff were not always in line with the provider's normal shift patterns and were not meeting the needs of the home. This included staff other than care staff. Action had been taken to address this prior to the inspection.
• Managers had inherited the need for a full-time chef, activities co-ordinator and more nurses. At the time of the inspection a full-time chef and activities coordinator had been identified and they were due to start soon.
• The managers confirmed the kitchen hours had always been appropriately covered and a member of staff had been allocated hours, albeit not full-time, to support social activities.
• Agency nurses were used where there were nursing vacancies. Managers were focusing on a more local recruitment campaign for nurses.
• Call bell response times were monitored, and some call bells had been recorded as sounding for too long; over 5 minutes. Staff had been reminded that call bells must be answered in a timely manner to establish if people were safe. Call bells recorded as sounding longer that 10 minutes had been investigated in line with the provider's expectations. These had been predominantly due to emergencies occurring or at busy times. Managers had addressed this by reviewing again, the home's routines and where staff were at these times. In some cases staff had attended a person but forgotten to re-set the call bell and external door alarms had not been switched off and re-set when the door had been closed. Manager audits showed call bell response times to be improving.
• Staff recruitment files showed that staff were recruited safely. Appropriate checks were completed before staff started work. This protected people from those who may be unsuitable to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
• The provider's policies and procedures on safeguarding people were available to staff who were made aware of these during their induction training. The service worked in line with the locally agreed multi-agency safeguarding procedures. This meant they shared relevant information with other professionals and agencies who also have safeguarding responsibilities. These include the local authority, Care Quality Commission and the police.

• All staff had received training in how to recognise abuse and report concerns. There were processes in place for staff to raise other concerns, such as practice concerns to their managers. Action was taken in response to poor practice or unprofessional behaviour.

Assessing risk, safety monitoring and management
• Risks to people's health such as falls, pressure ulcer development, loss of weight, infection, bleeding and choking were identified, assessed and addressed. There were arrangements in place for the reassessment of these risks following accidents, incidents or a change in people's health or ability.
• Environmental risks were managed to ensure people remained safe. During the inspection we followed up actions taken by the managers to improve staffs' ability to evacuate people in the event of a fire.

Using medicines safely
• People's medicines were managed safely and administered as prescribed. It was important for one person's physical and mental health that their medicines were administered on time throughout the day. The nurse on duty was particularly aware of this and made sure the person received these, on time, throughout the day.
• Staff had received training to administer medicines and we observed safe practice being adhered to.
• 12 months prior to the inspection there had been an increase in medicine recording errors. These were predominantly missing staff signatures on people's medicine administration records (MARs). A missing signature puts people at risk because the MAR does not then give an accurate record of what people may or may not have been given. An increase in the use of agency nurses had contributed to this. Improvements to the monitoring of people's MARs, by the managers, and the use of more regular agency nurses had resolved this. In the three weeks prior to the inspection there had been no errors.
• Some people required medicines to be used in an emergency, such as in the event of an epileptic seizure or catastrophic bleed. Nurses and some care staff were trained to administer these medicines.
• Arrangements were made to ensure end of life anticipatory medicines were prescribed and made available, so these could be administered at the end of people's life, if needed, to keep them comfortable.

Preventing and controlling infection
• Arrangements were in place to keep the home clean including equipment used to care for people.
• A protocol was in place to ensure all equipment used for enteral feeding was kept clean and changed regularly to prevent infection. Enteral feeding is when people receive their nutrition through a tube, through their nose or directly into their stomach or intestine.
• Staff were aware of the risks associated with sepsis and monitored people appropriately to ensure they received early medical support if this was needed. Monitoring was also in place for other potential infections such as chest infections, urinary tract infections and wound related infections.
• The staff worked collaboratively with visiting healthcare professionals to ensure people and staff were provided with the flu vaccine each year.

Learning lessons when things go wrong
• The managers were working with staff to empower them to feel able to discuss with them, things that were not working or which did not go to plan so lessons could be learnt and improvements made to people's care.

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 the last inspection this key question was rated as Good. At this inspection this key question remained the same. 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 them receiving care at Rodley House. The registered manager had been to assess one person's needs during the inspection. This person had required an urgent assessment, so they could access the home quickly.
• The assessment had considered current standards, guidance and legislation. For example, in relation to obtaining the person's consent for moving in and receiving care.
• People's abilities and needs were assessed in line with their protected characteristics, on an on-going basis so changes in these were identified and accommodated for in the care delivered. This was evident in one person's case following reassessment of their health needs where nurses adjusted care and treatment to meet the person's decline in health.
• The provider's policies and procedures ensured people were treated equally. Arrangements were made to meet people's different cultural and religious preferences.
• New lead roles had been introduced to support best practice within the staff team. For example, in falls prevention and dementia care.
• Work was being completed by both the provider and managers to safely implement guidance developed by The International Dysphagia Diet Standardisation Initiative (IDDSI). This was international changes in terminology and definitions relating to textured modified foods and thickened fluids, used to help people swallow their food and to prevent choking.

Staff support: induction, training, skills and experience
• The managers were keen for staff to receive any training they needed to improve their skills and confidence. Staff had already completed a one to one session with the manager, so their learning and development needs had been discussed along with any other support they may need.
• The staff training record showed that staff had received training in basic subjects required to carry out their work safely. These included infection control, food hygiene, information governance, safeguarding adults, responding to people's distress, emergency life support (which included choking), safe moving and handling and health and safety related subjects.
• Some staff held additional qualifications in care and knowledge in areas such as dementia care and end of life care and could support less experienced staff to meet people's needs correctly.
• Further training in person-centred care and communication had been provided by one of the provider's Admiral Nurses (a specialist nurse who supports people who live with dementia and those who care for them) to care staff. Care staff including care assistants, senior care assistants and team leaders had received this training. They had also been provided with training and support in relation to managing behaviours which could challenge.

• A relative said, "I think the staff are well trained, they seem to know what they are doing."

Supporting people to eat and drink enough to maintain a balanced diet
• People's weight was monitored and any concerns relating to this, their appetite or ability to eat and drink safely were referred to their GP.
• People who were at risk of choking were referred to a speech and language therapist (SLT) for assessment. One person had difficulty in swallowing during the inspection and had nearly choked. Staff had responded immediately to this and had managed to dislodge the food. An immediate request for a referral to a SLT was made. In the meantime, further risk of choking was reduced by changing the texture of the person's food and making sure staff were present when they ate.
• People who had lost weight were provided with support from staff at mealtimes and additional calories were added to their food by means of adding cream, butter and whole milk to their food. A relative said, "[Name] was not eating much, she was underweight, but the staff have worked together to encourage [name] to eat and she has put on weight. So, that is good."
• People had commented to us that they would like a better choice of food. Managers had already discussed changes to the menu, with the new chef, and people were to be involved in making suggestions on this once the chef was in post.
• Staff worked with community dieticians to ensure people who received their nutrition through a tube into their stomach or small intestines, received the level of nutrition and fluid they required.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Staff in the home liaised with community nurses, GPs and other healthcare professionals to support people's health needs. People also received support to attend health appointments. One person said, I have been out to healthcare appointments, to the opticians and GP. I get my appointments okay for my health." Another said, "I get my nails done and I like that." A chiropodist visited the home regularly.
• Senior staff liaised with hospitals and local authorities, so people could access adult social care support when needed.
• People were encouraged to take part in exercise and movement sessions as part of supporting a healthier way of living.

Adapting service, design, decoration to meet people's needs
• The building was a purpose-built care home, although older in style, which had been adapted to accommodate people's physical disabilities. There was a lift to the first floor and ramped entrances to the building and garden for easy wheelchair access.
• Bathrooms and toilets had adaptions to help those with a physical disability use these more easily. These included grab rails, hoists and call bells.
• Some areas of the home were being altered to better support people who lived with dementia and who had a visual disability. The walls and furniture in the dining room were of a similar colour and shade of grey. For some people the lack of contrast in colour made it difficult for them to distinguish the chairs, tables and windows from the walls. A bright, contrasting colour had been chosen and new curtains, table cloths and ornaments in this colour had been purchased and were due to be added to the room.
• Improvements in signage around the home were due take place to help people orientate themselves.
• Bedrooms recently decorated had not been decorated in one bland colour. These now had a focal wall, decorated in a bright contrasting colour. This would help people recognise their bedrooms and help bring shape and form to items of furniture placed in front of these walls.
• The registered manager was considering how the home's environment could be better used to meet people's individual needs longer-term. An additional sitting room had already been provided on the ground floor, which had helped resolve the over-crowding in the home's main lounge. Plans were being considered

to provide another sitting room on the first floor which, would provide a dedicated sitting area for people who lived with dementia.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• The principles of the MCA were adhered to and people unable to provide consent to live in Rodley House had authorised DoLS in place. Arrangements were in place to review these with the supervisory body when they expired and to ensure any conditions to these were met.
• The provider's admiral nurses were available to provide support with the process of assessing people's mental capacity and with making decisions in people's best interests. Staff ensured people's care and treatment was provided lawfully.
• Where people lacked mental capacity, their representatives were consulted about decisions made on their behalf and in their best interests. People's legal representatives were part of the decision-making process.
• Staff ensured people had independent advocacy where this was needed.

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 has remained the same. This meant people felt well-supported, cared for and treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People told us staff were kind and friendly.
- One person said, Yes, generally staff are friendly here, they are okay." Two people who had lived in the home for some time said, "It's alright, staff are friendly" and "I've got company here and I get on well with the staff, I think they're very kind."
- One person said, "I have a Key Worker, she listens to me and makes sure I am happy with everything."
- Another person said, "If I am not feeling well, I can stay in bed when I want to which is lovely. Nobody makes you feel like you have to get up."
- A relative said, "[Relative name] has a Key Worker, she is very friendly…"
- There were no visiting restrictions and relatives were welcomed.
- Many staff had worked in the home for some years and were clearly committed to both the home and the people who lived there.
- The registered manager told us their care values centred on the six C's in care; care, compassion, courage, communication, commitment and competence. They told us they considered most staff to hold these values, but they were aware some staff required support to improve their communication skills and implement this in practice.
- We spoke with one member of staff who had just been given the role of dignity lead. This role would support the managers' plans for a more person-centred approach to care and help staff apply the six 'C's in practice.
- Good support was seen at lunch time when people were supported to sit where they wanted to, provided with choices of food and drink and when staff spoke with people in a friendly and relaxed way.
- An example of effective and supportive interaction was seen when one member of staff took their time to give one person unhurried verbal prompts as the person negotiated sitting down in a chair. The member of staff also waited while the person adjusted themselves to check if they were comfortable before they left.
- Another example of a positive and meaningful interaction was observed when a member of staff talked to a person about their pet. The staff member supported their verbal conversation by also pointing to and referring to an object close by. This helped this person engage in the conversation which they clearly enjoyed.
- Sensitive, caring and compassionate interactions were also observed with one person who was feeling overwhelmed by events happening to them. The deputy manager and one other member of staff crouched down in front of this person, when they spoke with them, so the person could see and hear what they were saying. They spent time with the person helping them to understand what was going on around them and to

make independent choices at this time. Reassuring touches were used to help the person feel safe and cared for and the staff worked with this person at the person own pace.
• A nurse demonstrated compassion and took great time and effort during one shift to ensure one person's medicines were reviewed on that day by their GP. They were focused on ensuring this person could feel as comfortable as possible, as soon as possible, and that their dignity was maintained at a time their health was failing them.
• We observed personal care and treatment to be delivered in private and any discussions about people's treatment took place where others could not overhear; for example, in the nurses' office.
• Written information about people's care and treatment was kept secure.
• When talking with one person about their ability to be independent and make choices they confirmed they could spend their time as they wished." Another person told us they were self-sufficient, which is how they wanted to remain. They told us the staff supported them in the areas they needed support in.
• We observed staff supporting people's independence when they helped people to walk and at mealtimes by adjusting their level of support when people could manage things independently.

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 has 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

• Care plans were in place for most aspects of people's care and reviews of care plans had taken place according to the provider's expectations. The managers told us some care plans required amendment to make them more personalised. Care plan paperwork had been altered by the provider and care staff were receiving training on this to support them to be able to write new care plans in a personalised way. This work was part of the managers' on-going improvement plan.

• Plans of care for people with higher risks and more complex needs had already been reviewed and updated by managers and nurses, to ensure staff and visiting professionals had up to date information about these people's needs, care and treatment. This had included all wound care plans and associated records.

• One person had been exhibiting behaviour which was becoming more challenging for staff to manage. At the time of the inspection there was no specific written guidance in the person's care plans on how to manage this. Staff had sought advice from an Admiral Nurse, during training taking place at the time of the inspection, on how best to support this person's needs. The admiral nurse subsequently added guidance to the person's written care plans on how to provide positive behaviour support to this person.

• To promote better outcomes for people who lived with dementia a dementia lead role had been developed. This member of staff's role was to support other staff in the care of those who lived with dementia and increase staffs' knowledge generally, about different types of dementia and the impact these had on people and their behaviour.

• Care records kept by staff showed they knew people's needs and preferences well. Arrangements were in place to update staff on people's health and care needs, particularly if these altered, to ensure people's needs continued to be appropriately met. This included a robust verbal staff handover process each time staff came on duty. We observed the altered care of one person be handed over to staff when they came on duty.

• Part of the deputy manager's role was to be more involved with people's care delivery and to monitor the quality of care delivery. Staff confirmed this manager was available for advice or guidance when they needed it. This was also the case for the nurses and senior care assistants who staff found supportive. One senior care assistant was able to explain to us in detail one person's complex needs and care.

• Relatives were clearly involved in their relatives' care and able to express their views about this. One relative (the person's representative) told us they spoke to their relative's Key Worker. They said, "We discuss what we think is best for her [the person receiving care] so it feels like a real partnership effort."

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.
• Care plans were in place giving guidance to staff on people's communication abilities and how best to communicate with people. This included information about specific speech related problems, hearing loss and sight related problems. However, from what we observed people did not always receive the support they needed to support effective communication.
• There were arrangements in place for information to be provided in different formats such as large print, different languages or audio. The pre-admission assessment for one person had considered the person's AIS needs. The manager was going to explore these further with the person as they suspected they may need information to be provided in large print or audio.

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
• The home had been looking to recruit a new activities co-ordinator (previous co-ordinator had left three months prior to the inspection). We were informed during the inspection that one had been found and they would be starting work as soon as all recruitment checks were completed. In the interim, arrangements had been made so people could continue to enjoy and take part in organised activities. One relative said, "There is a schedule of activities, though carers [the care staff] cannot run activities at the same time as caring." Another relative referred to the activities as being "generalised" and told us people were not asked what they would like to do.
• Records forwarded to us by the provider showed that group activities, time spent with people on a one to one basis and trips out had continued to take place on a regular basis. These records also confirmed that people had made specific requests for their favourite activity to take place and this had been met. A meeting had been held with people and relatives giving them an opportunity to talk about their activity preferences and suggestions around activities. Suggestions made by people had been followed through.
• In the absence of an activity co-ordinator one member of staff had agreed to take a lead role in co-ordinating activities for people. They had been given designated hours to do this and had also come in on their days off to support people with activities on a one to one basis. Activities already booked by the previous activities co-ordinator had continued to take place. One person told us they had enjoyed a visit by people with owls and a harpist. Records forwarded to us by the provider showed activities had also been provided by the care staff on a regular basis. These showed that people's requests for popular activities had been met. One person had requested an exercise game and another person had enjoyed arts and crafts sessions and flower arranging.
• We observed care staff organising and leading activity sessions and took part in one. Levels of engagement varied but these were monitored and recorded to ensure activities continued to meet people's abilities as well as their preferences. Managers told us that the provision of meaningful activities would continue to improve once the new activity co-ordinator started. A 'whole home' approach, where meaningful activities were part of everyday life for people at Rodley House would also continue to be promoted.

Improving care quality in response to complaints or concerns
• The provider had a complaints policy and procedures in place which were on display for people and visitors to read. Information was given about how to make a complaint when people first moved into the home. One person told us they knew how to make a complaint.
• The managers operated an open door and wanted people to feel able to report any concerns or areas of dissatisfaction they had to them, so they could address these proactively.
• The manager confirmed they had not received any complaints, which had required formal investigation since they had been in post. They told us they had completed numerous conversations with some relatives who had queries or concerns about their relatives' care. This was usually to explain to them why care was

being delivered in a certain way.

End of life care and support
• Staff supported people at the end of their life to have a dignified and comfortable death.
• People's end of life wishes had been explored with them or with their representatives and staff took action to ensure these were met.
• This included being proactive and liaising with community healthcare practitioners to support people at the end of their life.
• People with deteriorating conditions were known to staff and their end of life needs considered in advanced care planning. This ensured that when these people entered their 'last few days of life', arrangements were in place to support them in the way they wanted to be supported.

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 Good. At this inspection this key question remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

At the time of the inspection the manager of the home was not registered with the Care Quality Commission (CQC). Shortly after the inspection they were successfully registered with the CQC. When managers are registered with the CQC 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• At the time of the inspection the manager had been in post for just over two months. An experienced care home manager they worked with the provider to make changes to the service. The action taken further supported a person-centred approach to people's care, treatment and social activities. A review of how staff were deployed had taken place and some changes to staffs' working routines and responsibilities had also taken place to ensure these met the needs of the home.

• The deputy manager, also in post for just over two months was an experienced adult social care practitioner. They shared the same vision for the home as the registered manager and provider and complimented their skills and areas of knowledge. The registered manager said, "It's about having a happy home where residents feel happy, safe and secure and can have their needs met as required."

• Both managers had listened to advice and ideas from the nurses, which had resulted in improved care and treatment plans for people's more complex needs. Guidance in people's care plans, for staff, had also been reviewed to ensure it was current.

• Regular and competent agency nurses were used to support the home's permanent nurses and a consistent and effective nursing team ensured people's health needs were met.

• Managers were in the process of recruiting new and additional staff to fill gaps in staff requirement. A new chef due to start work imminently would help improve food choice and the quality of the meals provided. They had already discussed new menus with the managers. A new activities co-ordinator, also due to start work soon, would continue to provide opportunities for people to take part in activities they enjoyed.

• Action was being taken to improve working relationships with external healthcare professionals, so a better service could be provided to people in their own home.

• Managers were supporting staff to be more empowered and included in making decisions about how the home was to operate; there had been a focus on team building. The registered manager said, "Staff need to feel proud and caring is team work."

• Managers had facilitated ways for staff to feedback on the changes being made. One way had been a 'what works and what does not work' style of discussion. The registered manager said, "If you dictate you will not

take the staff with you." We spoke with staff who told us, although there were lots of changes taking place, these were positive changes and they felt able to voice a view which both managers listened to and considered.
• Both managers understood their responsibilities in relation to the law and compliance with regulations. We received notifications as required and the home's previous inspection rating was clearly displayed.
• Managers were aware of their quality monitoring responsibilities and completed the provider's yearly plan of audits to ensure shortfalls in risk management, practice and services provided were addressed.
• An action plan was in place which acted as an aid memoir for the managers on what improvements were necessary following completion of the audits and what was planned as on-going improvements to the service. The managers referred to the on-going improvement plan as a 'living document', which evolved as actions were completed and further actions for improvement were added.
• A review of this showed that actions, already identified by the provider, following their last quality audit in April 2019 and which had been inherited by the new managers, had been largely met. Other actions were progressing well, including those identified by the managers since they had been in post. On-going improvement included the personalisation of people's care plans, the provision of new menus to include printed table menus (once the new chef's menus had been discussed with people), additional opportunities for meaningful activities, improvement to the dining room's colour scheme to help some people be able to more clearly define space and objects, including other planned improvements to the environment, such as new stair gates and a newly formed sitting room on the first floor.
•Representatives of the provider were supporting the managers in the improvements they were making and reviewing those which had been successfully completed during their provider monitoring visits.

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; Continuous learning and improving care
• Managers understood that when things went wrong people, or their representatives had a right to an explanation, apology and information about what action would be taken to avoid a recurrence. One relative told us they had received an apology after an appointment had been made for their relative and they had not been informed about this. They confirmed this had not happened since.
• The management style adopted by the managers supported on-going learning from the feedback received from relatives, people and staff. They were open to constructive criticism and wanted staff to feel confident to constructively challenge poor practice so learning could be derived from this.
• Managers demonstrated that they were continually reflecting on their decisions to ensure these had positive outcomes for people and the general management of the service.
• Both managers kept themselves professionally up to date through on-going learning, continual professional development (CPD) and keeping up dated with current best practice so this could be implemented in the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Meetings had been planned for the next year to formally meet with people, relatives and staff. Meetings were used to both communicate important information but also to gain feedback and to hear suggestions which could be used to improve the service further. In the last relative meeting managers had reminded relatives of how to raise a complaint if they needed to.
• Staff meetings had been held to ensure staff were fully aware of the changes being made and the progress of some of these. There had been a period of consultation with staff for some of these changes. One member of staff confirmed they felt fully informed about the changes taking place.
• Daily heads of department meetings were working well, and we attended one meeting during the inspection. These gave heads of department time to share problems or issues from their departments with other heads, but also for risks or safeguarding concerns to be discussed and acted on immediately.

Information from these meetings was then cascaded back to the individual team members by the heads of department.

Working in partnership with others
• Steps were being taken to improve how the home could work better with other partners in care.
• The managers and senior staff ensured they communicated with and worked collectively with commissioners of care to benefit people.
• Links with volunteer groups and individuals were either being re-established, or new ones were being made, so the home could increase its net-work of volunteers to help support people's interests.