

Methodist Homes Brookfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement 
Is the service safe?	Requires Improvement 
Is the service effective?	Requires Improvement 
Is the service caring?	Requires Improvement 
Is the service responsive?	Good 
Is the service well-led?	Requires Improvement 

Overall summary

We inspected Brookfield care home on the 21 and 24 November 2014. This was an unannounced inspection. The previous inspection of this service was a follow up inspection carried out in December 2013. The service was found to be meeting all of the standards inspected at that time.

Brookfield is a purpose-built modern home that provides care for up to 66 people. At the time of our visit 61 people were living at the home. The ground floor was used to support people with general nursing needs and the first floor was used to support people living with dementia.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People did not receive consistent care across the home. People living on the nursing unit were more satisfied with the care they received than those living on the floor for people with dementia. Our observations supported these

Summary of findings

comments. Nurses were responsible for planning the staffing across the home. However, there was no system to ensure the skills and experience within the team was shared across the home to ensure every person in the home benefited from safe, effective and compassionate care. We also found that there were systems in place to monitor the quality and safety of the service but they were not always effective.

Whilst staff received training, it was not always delivered in a way that supported staff to embed their learning into practice. Staff gave varying feedback on the support and supervision they received. Some felt well supported, but others told us the supervision and appraisal system did not support them to improve.

People and their relatives told us staff were kind and caring. Comments from people included, “they treat me well and are very caring”, “The care is the best thing about the home, they look after the patients”, “The staff have infinite patience, they are people that want to care”. However our observations didn’t always support these views. We observed interactions on the first floor dementia unit that were not caring.

People on the general nursing floor told us they felt safe and supported by staff. Care plans identified risks to people's health and welfare. Risk assessment and support plans were in place to enable staff to deliver care safely. However, on the floor for people with dementia when peoples support needs changed, risk assessments were not always updated to reflect this.

People told us the service was responsive. One person told us, “the service support me well, they know when I need the doctor”. Another person told us, “they are very responsive, they keep an eye on me through the day as well”. Staff recorded and monitored people’s health and wellbeing and sought appropriate healthcare professional support promptly when people needed it. People benefited from activities they could engage with. People enjoyed a quiz, playing board games and were also entertained by a guest singer.

Staff spoke positively about the team and the leadership. They described the registered manager and other senior staff as being supportive and approachable. Staff described a culture that was open with good communication systems in place. Staff were confident that the management team and organisation would support them to raise concerns. One person told us, “the home may not be perfect but it has come an awful long way under this leadership”.

We found that there were systems in place to monitor the quality and safety of the service but they were not always effective.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. We found three examples of risk assessments that had not been updated to reflect people's changing needs.

There were sufficient numbers of staff to meet people's needs.

Medicines were administered safely. However, medicines and creams were not always stored safely.

People were protected from the risk of abuse as staff had a good understanding of safeguarding and the service had an effective procedure in place to manage issues if they arose to ensure people were safe.

Requires Improvement



Is the service effective?

The service was not always effective.

People were not always supported by staff who understood their needs. Support guidelines were not always clear or not always followed by staff and staff did not always receive appropriate supervision, appraisal and training.

People on the nursing floor felt supported by knowledgeable and competent staff. However, people's experience of the dementia floor varied.

Requires Improvement



Is the service caring?

The service was not always caring. We observed occasions where staff interactions were not caring. For example staff did not always acknowledge people.

Some relatives and professionals said people living with dementia were not always understood.

People were not always cared for by staff who showed respect to them although we saw many visible positive relationships between staff and people using the service.

Requires Improvement



Is the service responsive?

The service was responsive. People we spoke with felt the service was responsive.

We saw that when people's needs changed the service responded. People said they knew who to talk to if they had any concerns and felt there would be a quick and positive response.

Good



Is the service well-led?

The service was not always well led. We found that there were systems in place to monitor the quality and safety of the service but they were not always effective.

Requires Improvement



Summary of findings

Whilst staffing levels were adequate in numbers there was no system to ensure the mix of skill were adequate to meet people's needs.

Staff spoke positively about the team and the leadership. They described the registered manager and other senior staff as being supportive and approachable.

Brookfield

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 21 and 24 November 2014. It was unannounced. The inspection team consisted of two inspectors 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.

Our last inspection in December 2013 was to follow up on action we had required the service to take following inspections in June 2013 and October 2013. The inspection in December found action had been taken in relation to support for people living with dementia and the service was meeting all the standards required.

At the time of the inspection there were 61 people living at the care home. Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well

and improvements they plan to make. We also reviewed the information we held about the home. This included notifications about important events which the service is required to send us by law. We also contacted and received feedback from four health and social care professionals who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 17 people who were living in the home, 11 visitors, nine care staff, the cook, the deputy manager and the registered manager. We spent time with people in the communal areas observing daily life including the care and support being delivered. As some of the people who lived in the home had dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at eight people's care records, six staff records and the training matrix as well as records relating to the management of the service such as quality assurance audits and duty rotas. We looked around the building and saw some people's bedrooms (with their permission), bathrooms and communal areas.

Is the service safe?

Our findings

Risk assessments were reviewed monthly or when changes in people's needs had been identified. For example, one person who had been identified as at risk of falls had specialist equipment in place to support them with their mobility. Each person had a 'safe system of work' record that indicated the support they needed with detailed 'methods and precautions'. However, we reviewed three risk assessments had not been updated with people changing needs. For example one person's needs had changed to require nursing in bed, but their risk assessment had not been changed to reflect this. Staff we spoke with understood the risks of the change but they were not documented.

This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were sufficient numbers of staff to meet people's needs. On both days of our inspection there were sufficient numbers of staff. Duty rotas confirmed that planned staffing levels were adequate to meet people's needs. People who used the service said they felt the home was "a little short staffed" and "could be a bit short" however, they also said staff were "still very quick to respond" and "there were always staff to help them when needed." There was a calm and pleasant atmosphere throughout the home. Staff said agency workers were not regularly used in the home because existing staff covered for sickness and annual leave when required. They [staff] said this was to make sure that people were supported and cared for by care staff who knew them and understood their needs.

People on the general nursing floor told us they felt safe and supported by staff. Comments included, "Yes I am very safe, staff are very thoughtful" and "I feel nice and safe". A relative said "they look after Mum really well and I come at different times every day it always feel safe" whilst another person and their relative said "staff have been absolutely brilliant, people are protected from harm". One person on the first floor where people living with dementia were being supported said "I feel safe here, it's ok".

However, our observations didn't always support people's comments. On the first floor dementia unit we found creams and hazardous substances in people's rooms. Two bedrooms had their doors left open and medicines were within easy reach. We saw several people walking freely in and out of these bedrooms. There was a risk to these people if they chose to handle these medicines. We sought advice from a pharmacy inspector after the inspection who advised risk assessments should be in place for this and safe storage. A risk assessment was not in place. We raised these concerns with the deputy manager who took immediate action, creams were removed and staff were reminded of their duty to ensure they were stored safely.

Nurses administered medicines safely and supported people to take their medicines in line with their prescription. Medicine administration records (MAR) charts were completed to show when medicine had been given or if not taken the reason why. Where people had controlled medicines the amount of medicines documented as being in stock on the controlled drugs chart corresponded with the actual amount of medicines in stock.

People were protected from abuse by staff who were knowledgeable about safeguarding adults. Staff said they had received training in safeguarding people, and we saw certificates on staff files which confirmed this. Staff knew how to raise a concern if they suspected a person was being abused. Staff described how they would report any safeguarding concerns they had to the manager, or if they felt they need to report externally to the local authority and Care Quality Commission (CQC). Safeguarding records showed that events had been appropriately referred and action had been taken to ensure people were protected. There were also arrangements in place to deal with foreseeable emergencies.

Relevant checks had been completed before staff worked unsupervised at the home. These included employment references as well as Disclosure and Barring Service (DBS) checks. These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people.

Is the service effective?

Our findings

There was a care plan in place for one person living with dementia who could present behaviours which challenged. This person presented challenging behaviours on three separate occasions during our inspection, but no staff acted in line with this person's support plan. The support plan also stated each incident should be documented to enable staff to identify underlying reasons for this behaviour, which did not happen consistently. A recent review of this person's care with their social worker recommended that an ABC chart should be completed. An ABC chart is a technique for understanding challenging behaviours, analysing these behaviours, and then creating effective responses. This was not happening. There was a risk of this person not receiving effective support due to staff not supporting the person with their behaviour and what they were trying to communicate.

We also identified issues on the first floor dementia unit. One person was regularly shouting out. This person's support plan detailed they shouted out when they were contented. However, we observed this person becoming increasingly agitated. One person said "I don't think we really know why they do it, but it upsets other people". Guidelines in place to support this person stated clearly they liked company and physical contact. We observed extended lengths of time where this person did not receive any support. One relative walking past this person's room said, "it's like it's just become normal to the staff". Another person had support guidelines in place for meal times due to risk of choking, however these guidelines were not being followed.

We observed one person in their room who had speech and language therapist (SALT) recommendations in place for thickened fluid and support with drinking small sips. This was due to risks of aspiration (aspiration occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs). This person had capacity to choose not to have their fluids thickened. However, this person was left for long periods of time with fluid which was not thickened and was not supported when drinking. There was no risk assessment in place for this.

These issues were a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff training included a mixture of e-learning and classroom based training. Training certificates showed staff had completed the services mandatory training. This included moving and handling, nutrition, infection control and first aid. However two staff members had completed numerous training courses on the same day. Staff said this "sometimes made it difficult to remember everything". Another staff member said "training has improved a lot, we get much more than we used to". However, not all staff were applying training in practice. People being supported with dementia were not always understood. One member of staff referred to a person disrespectfully, using a derogatory term relating to the behaviour they presented. This staff member said, "we get dementia training but it's quite short, we could do with more". One relative said, "staff get training for dementia care and challenging behaviour, but some staff need more". This person felt people were not always understood. Not all staff were able to explain why the behaviour of some people living with dementia may be challenging. One staff member said "they often do it for attention". On two occasions people walking with a purpose were told by staff to go and sit down. On neither occasion did the staff member attempt to understand the person's needs. One professional we spoke with said, "people living with dementia were not always understood".

Some staff said they had regular supervision meetings and were able to get support whenever they needed it. One staff member said "staff support is better than it ever has been". However, staff were not always supported to improve the quality of care they delivered to people through the supervision and appraisal process. Supervision notes often detailed reminders to staff rather than evidence of support. Some staff commented, "supervision isn't really a space for me" and "I don't get much from supervision to be honest". Staff files did not contain a development plan. Staff responsible for supervising staff had not received supervision training, although there was a plan for this to happen.

These issues were a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People on the nursing floor felt supported by knowledgeable and competent staff. One person said "they know what to do and are good at their jobs." A relative said, "We feel confident our relative is in good hands." However, people's experience of the dementia floor varied. One

Is the service effective?

relative said some staff just weren't "good enough to administer the care that people deserve". Our observation across the home identified that care on the first floor nursing unit was effective. We saw people with mobility needs being supported in line with their support plan and people who required pressure relieving equipment being supported effectively with equipment in place.

People benefited from a varied menu of healthy home cooked food. People said "Food is good and there's a good choice." and "The cooking is really very good and they provide the very best. You can have whatever you want to each day and at any time of day or night." and "Meals are excellent with a first course and puddings." Alternatives were available for people who wanted something different from the menu options. Drinks were available to people throughout the day.

On the first day of inspection not all food and fluid charts were being completed. This had been resolved by the second day of inspection and only people who required

these charts had them. Staff maintained good monitoring of people's weights, when they had increased concern they weighed people weekly and ensured that people were supported to maintain a healthy weight.

Staff we spoke with were trained and prepared in understanding the requirements of the Mental Capacity Act 2005, and the specific requirements of the Deprivation of Liberty Safeguards (DoLS). We saw mental capacity assessments in people's files regarding decision relating to their health and finances. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. DoLS ensure people's rights are protected, care homes must make formal applications and have authorisation to impose restrictions on people who do not have capacity to consent. The registered manager had a good understanding of their responsibilities in relations to DoLS but there were no DoLS in place at the time of our inspection, but the service was in the process of reviewing applications that needed to be made as some people could not leave the home freely without supervision.

Is the service caring?

Our findings

People and their relatives said staff were kind and caring. Comments from people included, “they treat me well and are very caring”, “The care is the best thing about the home, they look after the patients”, “The staff have infinite patience, they are people that want to care”, and “they [staff] are kind people and good people”. A relative said, “I am hoping to move here myself, it’s just wonderful”. We observed some very caring interactions between staff and people on the general nursing floor. Staff were caring, warm and respectful. We observed a number of interactions that were engaging. We saw that these encouraged people to interact and engage with each other in a very meaningful way.

We saw a number of caring interactions on the floor supporting people living with dementia. For example we observed a member of staff talking to a person about a picture of how they would like their hair. This information was also in their person’s care support plan. However, we also observed that on three occasions on the dementia unit staff walked into a room and did not acknowledge people before leaving. One relative on the floor supporting people with dementia said “The carers themselves are kind and gentle and you know that you can trust them, but sometimes they forget that the person has had a life and has had children and been a mother, they need to understand the people inside”. Staff did not appear to know about people’s life history. One staff member said “I hear things, but I only really read the support they need”.

People on the nursing floor said they felt that they mattered. One person said “I was asked my opinion about the decoration and they listened”. Care staff described how they made sure people had choice. One said, “We never assume, we always ask what people would like such as getting up times or if people want to stay in bed they do. One lady likes to soak in the bath, so she does”. One person

found it difficult to communicate verbally. When staff spoke with this person they maintained eye contact and used body language to communicate. Another person had written instructions for staff on how to best support them because they found it difficult to speak. These instructions were clearly recorded on their care plan. Staff followed these instructions when offering this person a cup of tea and this had a clear positive impact on this person.

Staff knocked on people’s bedrooms when entering, even if the bedroom door was open. One person and their relative said “staff always knock and say hello. They look after me well.” Staff spoke with people in a polite friendly way. Care workers assisting people from the lounge to the dining room at lunch time knew how to support each person in the way they wanted. Some people could manage once helped from their chair whilst others needed support with walking to the dining room. Care workers were gentle and reassuring when supporting these people.

People were involved in decisions about their end of life care. One relative said they had been able to discuss their relative’s preferences with the manager and “had gone through and agreed their end of life wishes which were in their care plan.” Conversations with people had been recorded which showed people had been involved in planning their care. For example, their preferred place of death and preferences for undertakers. However, where ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) documentation was in place this was not always completed in line with current guidance. These documents did not clearly state the reasons the form was in place and who had been involved in the decision. We have shared this with our colleagues in the primary medical services directorate and raised it with the registered manager. The registered manager agreed to review all DNACPR’s in place to ensure that they were fit for purpose and in line with current guidance.

Is the service responsive?

Our findings

People said the service was responsive. Comments included “the service support me well, they know when I need the doctor.” and “they are very responsive; they keep an eye on me through the day as well”. One relative said “The staff are very responsive and never seem to get irritated”. During the inspection call bells were responded to promptly and care staff were quick to respond to people who asked for their help.

When people’s needs changed the service responded. For example care staff identified the signs that one person had a suspected urinary tract infection (UTI) and responded immediately. A UTI was diagnosed, treated and cleared up. Daily notes were used to capture people’s changing needs. One person had presented behaviours that challenged. Staff had made a referral to a mental health nurse to assist them to support this person.

The GP visited weekly or more frequently if required. Health and social care professionals said “care staff are person-centred and approachable” and “In my experience care staff know the residents well and respond to them brilliantly”. Professionals also described how people’s changing needs were identified to them and said “our advice is always followed.” Details of any professional visits were recorded in each person’s care record, with information on outcomes and changes to treatment if needed.

During lunch a staff member recognised that one person was “not looking themselves”. This staff member identified that they may be missing a possession they like to have with them. They went to get this for the person and it visibly cheered them up. We saw this detailed in the person’s care plan so staff were able to respond when they saw this person looked in a low mood.

People said there were lots of activities and they were supported to lead active lifestyles. Comments included “there’s always lots going on”, “We are encouraged to go out when we can” and “I have enjoyed playing board games with my friends and enjoyed the quiz today”. Arrangements had been made for people to attend the local church on Sundays and the chaplain visited the home and spent time with people. One person commented “they get some singers in and some are very good.” A singer visited on the first day of our inspection which people visibly enjoyed.

Some people said they did not want to get involved in the daily activities and preferred to remain in their own room. One person said “I prefer my own company, activities? No thanks.” Another person said that staff would come to their room to spend some “one to one” time with them. People said they could choose how to live their lives commenting “I am supported to be myself”, “I enjoy doing more” and “yes I can choose.” Each person commented that staff respected these choices.

People said they knew who to talk to if they had any concerns. One person said “I would call the manager. In the past I needed to complain and they sorted it out very quickly for me. They definitely look after me.” Another person said she was in an uncomfortable position in bed and said “I did tell staff and they did something about it” also “if I was unhappy I would tell the nurses.”

The provider had a complaints policy in place. The registered manager checked if people were satisfied with the outcome of their complaint. For example a complaint from a person’s relative regarding their relative’s appearance and hygiene was dealt with in line with the service procedure. It was documented the person was happy with the outcome.

Is the service well-led?

Our findings

There were a range of quality monitoring systems in place to review the care and treatment offered at the home. Some quality monitoring systems were used to make improvements to the people's care. For example, we saw audits identified gaps in people care plans that needed attention. However, there was no system in place to record the care plans that had been reviewed and actions taken as a result. The registered manager said this was done from memory on a unit by unit basis. In the absence of the registered manager it would not have been clear whose file would need to be audited.

The registered manager completed monthly reports across the service to identify key issues within the home. These detailed people with ongoing support needs such as pressure areas or weight monitoring. These reports also identified how many falls there had been. The most recent report for October 2014 detailed there had been no falls. However, we found through incident reports that there had been at least four falls in October. This meant the system did not always capture accurate information for the service to take appropriate action.

The inspection identified that the care provided to people on the nursing floor was of better quality than the care provided to people living with dementia. Nurses had responsibility for planning the staffing across the home. However, there was no system to ensure the skills and experience within the team was shared across the home to ensure every person in the home benefited from safe, effective and compassionate care. One staff member said, "we have enough staff, but it depends who is on, if we have too many new people it's tough, especially on this floor [providing care to people with dementia], it would be better to share the experience more equally as we end up calling on other staff anyway". One staff member said "I think the care across floors can vary as some carers are more experienced than others, the first day you were here we didn't have many experienced carers on the dementia floor". There was no assessment to identify the number of staff needed to safely meet people's needs; this is most commonly known as a dependency tool. These issues had not been identified by the management team.

These issues are a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Feedback received from health and social care professionals praised the standard of service offered to people; the registered manager's relationship with professionals and how the manager and other members of the management team communicated with professionals. One professional said "they (managers) are keen to deliver best practice and operate in a helpful and transparent way, engaging with stakeholders to learn from mistakes and develop the services in a positive way."

Staff spoke positively about the team and the leadership. They described the registered manager and other senior staff as being supportive and approachable. Staff described a culture that was open with good communication systems in place. Staff were confident the management team and organisation would support them to raise concerns. One relative said "the home may not be perfect but it has come an awfully long way under this leadership".

There was a positive culture where people felt included and their views were sought. Regular discussions took place between people, their relatives, the registered manager or other senior staff and any other professionals involved in their care. A relative confirmed the registered manager attended the care reviews and they had regular contact with the registered manager throughout the year. Relatives said they were always made to feel welcome when visiting and could speak with the registered manager or senior staff at any time.

Regular staff meetings highlighted any changes or concerns with people's care and support. Organisational changes including policy changes, health and safety and training were discussed. Staff had the opportunity to comment on the day to day running of the service and were encouraged to make suggestions. The registered manager listened to ideas from staff and had made changes.

There was a clear management structure for decision making and accountability which provided guidance for staff. Staff were confident and aware of how to raise any concerns and said that they would initially report to the registered manager. We saw examples of when this had happened and that concerns had been dealt with appropriately. The registered manager had a clear understanding of their responsibilities and told us that, They submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
People were not always receiving care that was planned in a way to meet their individual needs and ensure their safety and welfare.
Regulation 9 (1) (b) (i) (ii)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff
Persons employed for the purposes of carrying on the regulated activity did not receive appropriate training, professional development and supervision.
Regulation (23) (a)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers
The provider did not have an effective system to regularly assess and monitor the quality of the service and identify, assess and manage risks relating to the health, welfare and safety of service users.
The analysis of incidents that resulted in, or had the potential to result in, harm to a service user did not lead to changes to the treatment or care provided in order to reflect information.
Did not have an effective system for ensuring that decisions in relation to the provision of care and treatment for service users are taken at the appropriate level in relations to planning workers on shift.

This section is primarily information for the provider

Action we have told the provider to take

Regulation (10) (1) (a) (b) (c) (i) (d) (i)

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

People were not always protected against the risks of unsafe or inappropriate care and treatment due to records not always detailing their up to date needs.

There was not always a clear record of what action had been taken in response to incidents and accidents.

(20) (1) (a) (ii)