Methodist Homes

Brookfield

Inspection report

Little Bury
Oxford
Oxfordshire
OX4 7UY

Tel: 01865779888

Date of inspection visit:
20 January 2016

Date of publication:
25 February 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 20 January 2016. This was an unannounced inspection.

Brookfield is a care home providing nursing care for up to 66 people. At the time of our visit there were 63 people living at the service.

At a comprehensive inspection of this service in November 2014 we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These were in relation to the care and welfare of people, supporting staff, maintaining accurate care records and monitoring the quality of the service people received. The provider sent us an action plan to tell us how they would ensure the service met the legal requirements of the regulations. At this inspection in January 2016 we found improvements had been made. However, we also identified some other areas of concern.

People were asked for their consent before care tasks were carried out. However, staff did not fulfil their responsibilities under the Mental Capacity Act 2005 (MCA) because they had not always taken appropriate action where people might not have the capacity to consent to other decisions about their care.

People had a range of risk assessments in place. However, the service had not ensured people were always protected from the risks associated with their care in relation to falls, pressure area care and the administration of medicines.

People felt safe when being supported by staff. Staff were clear about the action they would take to keep people safe from abuse. People and staff were confident they could raise any concerns and these would be dealt with.

People told us there had previously been staff shortages but now felt there were enough staff to meet their needs. There had recently been new staff employed at the service. There were enough staff on the day of the inspection.

People told us staff were kind and caring. People looked well kempt and were dressed appropriately for the weather. People felt respected and valued. However, we noted some interactions that did not demonstrate people were always supported in a respectful way.

People were involved in their care planning. They were provided with person-centred care which encouraged choice and independence. Staff were aware of people's preferences in how they wanted to be cared for. People were supported to maintain their health and were referred for specialist advice as required.

Some aspects of the service required improvement to ensure it always met the needs of people living with

dementia. This was in relation to the activity provision and decoration of the units where people were living with dementia.

People enjoyed the food and were supported to have their nutritional needs met. People were complimentary about the food and were given choice and variety. However, people who remained in their rooms were not always supported to drink outside of mealtimes.

The home had a registered manager. 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. The registered manager was supported by an area manager.

People were complimentary about the registered manager. However, there was not adequate leadership on the individual units which resulted in poor communication and confusion over delegated tasks between nursing and care staff. This put people at risk of not receiving their care in a safe, effective or responsive way.

We have made a recommendation about leadership.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Peoples risk assessments had been updated to reflect people's changing needs. However, people were not always protected from the risks associated with their care and treatment in relation to pressure area care and falls..

People were not always protected from the risks associated with the administration of their medicines.

People felt safe. Care staff were aware of their responsibilities to report concerns and knew how to do so.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported in line with principles of the Mental Capacity Act 2005 (MCA).

People were supported and encouraged to eat. However, people who remained in their rooms were not always supported to drink outside of mealtimes.

Areas of the service where people were living with dementia were not decorated in a way that followed good practice guidance for helping people to be stimulated and orientated.

People were supported to access other health and social care professionals to ensure their needs were met.

Staff felt supported and received a range of training to help them meet the needs of the people they were caring for.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff who were kind and caring. However, improvements were required to ensure people were always treated in a respectful way.

People were supported in a personalised way. Their choices and preferences were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Activities were not always planned and delivered in a way that met the needs of people who were living with dementia or people who were unable to visit the communal areas.

People were involved in the planning of their care. Care records contained detailed information about people's health and care needs.

People knew how to make a complaint if required.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to monitor the quality of the service were not always effective because they had not identified the issues we found during our inspection.

Nursing staff did not effectively lead or delegate tasks.

There was a positive and open culture where people, relatives and staff felt able to raise any concerns.

Peoples views were sought to improve the quality of the service.

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the Service under the Care Act 2014.

This inspection took place on 20 January and was unannounced. The inspection team consisted of two inspectors, a specialist advisor in dementia care 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.

Before our visit we reviewed the information we held about the service. The registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We spoke with one health and social care professional who 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.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with 14 people and 11 of their relatives/visitors. We spoke with 15 members of staff including nursing and care staff, activity staff, ancillary staff, the minister and the chef.

We looked at records, which included 11 people's care records, the medication administration records (MAR) for all people at the service and six staff files. We also looked at records relating to the management of the service, which included minutes of meetings, complaints and compliments, a range of audits and quality assurance feedback.

Inadequate

Is the service safe?

Our findings

At our inspection in November 2014, we identified peoples risk assessments had not been updated to reflect people's changing needs. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in January 2016, we found action had been taken. Risks to people's personal safety had been assessed and people had plans in place to manage those risks. These included areas such as falls and moving and handling. Risk assessments were regularly reviewed and updated when people's needs changed.

However, people were not always protected from the risks associated with their care and treatment. For example, one person spent all of their time in bed. Records in the persons care file identified they had been assessed as being at very high risk of developing pressure ulcers. The person had recently developed two pressure ulcers which were still being treated. The person had been provided with a pressure relief mattress. However, there were no records of this person having their position changed. The National Institute of Clinical Excellence (NICE) guidelines recommend that a person who has been assessed as at very high risk of developing pressure ulcers should have their position changed at least every four hours and the frequency of the repositioning required should be documented. During this inspection we observed the person did not have their position changed for five hours. We spoke with the staff who were supporting this person and the person then had their position changed. We received conflicting information from staff about the care this person received in relation to their pressure areas. For example, we asked one of the nurses on duty if the person was having their position changed and if there were any records of this. They told us they did not know and said they would ask a senior care assistant. Another nurse told us the person did not need their position changed as they could move about. We spoke with two care assistants about this person. One said they thought the wound had healed another said they had done some positional changes "last week" but they were not sure if there were any records.

Another person had been identified as at risk of falling. Their associated care plan stated "[name of person] should have their call bell within reach when in their room". We visited this person in their room; they were sitting in a chair. The call bell was on their bedside table and not within reach. Staff entered this person's room to deliver personal care and to assist the person to and from the dining room. They did not ensure the person had their call bell within reach. We heard another person calling for assistance from their room. They were in their bed and said they were cold and could not reach their call bell. We alerted a nurse who got the person a blanket. The nurse left the persons room but did not place the call bell in reach until prompted by the inspector.

People were not always protected from the risks associated with the administration of their medicines. For example, on two units we observed the administration of medicines was interrupted whilst nursing staff supported people with personal care or completed other tasks. On one occasion the nurse had dispensed some medicines and took them to the person. We noted the nurse did not return to the trolley to sign the person's medicine administration record chart. We looked at the chart and saw some morning medicines had been signed for and others had not. The nurse confirmed they had not given the person all of their

medicines at the same time because they had been interrupted. These frequent interruptions meant there was an increased risk of medicine administration errors and poor recording.

On one occasion we observed the nurse had left the medicines trolley unattended for 10 minutes. Although the trolley had been locked the keys had been left in the lock. This meant medicines were not stored safely.

Not all nurses who were on duty and responsible for administering medicines were aware of people's individual protocols for medicines prescribed to be taken as required (PRN). PRN protocols provide guidance to staff on when to administer the medication. Nurses who were aware of the protocols showed us peoples PRN protocols that were kept in a folder in the clinical room. The nurses did not have this information to hand whilst they were administering the medicines. This meant there was a risk PRN medicines might not be administered consistently or when required by the person.

These issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We shared our concerns with the registered manager who took immediate action to ensure these people were safe. We also raised an alert with Oxfordshire county council local authority safeguarding team.

There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why. However, we found two people's medicine administration records (MAR) where medicine administration details had been handwritten onto them. Only the signature of the person writing the information had been added. This was not in line with the provider's medicines management policy. Ensuring that handwritten entries on MAR sheets are witnessed is seen as good practice as it reduces the risk of transcription errors and possible administration of incorrect dosage; particularly because these medicines were provided from the pharmacy in individual boxes and not a monitored dosage system.

Before this inspection we had received concerns there was not enough staff to meet people's needs. On the day of the inspection there was enough staff to meet people's needs. There were ten care workers and four nurses on duty to support 63 people. People told us there had been shortages of staff in the past but they now felt there was enough staff to meet their needs. Staff told us there had been many new staff recently employed at the service but there had been recent occasions where staff had called in sick and cover could not be found at short notice. We looked at the off duty rotas and allocation sheets for the six weeks before our inspection and saw the required target numbers of staff had been allocated to work. However on 8 occasions there was one member of staff who had not come into work and cover had not been found. The service used bank staff to cover shortfalls but on these occasions cover could not be found. We discussed this with the registered manager who told us they had filled all of their existing vacancies but had advertised three further care staff vacancies. These were in addition to the services establishment but would mean that there would be cover if staff were off sick.

People told us they felt safe living at the service. Comments included: "Safe and sound. No problems at all, everything really good", "Feel safe because I've never had a problem" and always feel secure here. Don't have to worry" Relatives also told us they felt their family members were safe. One relative said "We are more than satisfied. [Name of person] is safe and well cared for". Another said, "Safe because he is cared for and taken care of".

Relatives told us they felt their family members were safe because they had equipment to keep them safe. For example, one relative said, "He is kept safe. He likes to try and stand but he falls. There is a sensor on his chair and if he gets up a buzzer goes off and alerts the staff". Another relative said, "[Name of person] is very

safe. He has padded bed rails in place and a pressure mat to alert staff if he gets out of bed by himself".

Staff had good knowledge of the provider's whistleblowing and safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly.

Safe recruitment procedures were followed before new staff were appointed to work with people. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role.

People and staff benefited from risk assessments in relation to the environment. Emergency plans were in place in the event of a fire at the service and people had personalised evacuation plans. The service had contingency plans in place for unforeseen emergencies that may impact on the service's ability to deliver people's planned care. For example, a power failure or bad weather.

Equipment used to support people's care, for example, hoists, stand aids and specialised baths were clean, stored appropriately and had been properly maintained. The service kept a range of records which demonstrated equipment was serviced and maintained in line with nationally recommended schedules.

Requires Improvement

Is the service effective?

Our findings

At our inspection in November 2014, we found staff did not always receive effective support from staff around behaviours which challenged. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in January 2016, we found action had been taken. All staff had received training in managing behaviour that challenges. Two staff had received more in depth training in this area and offered further practical guidance to staff in supporting people and planning their care. Staff were able to describe the individual triggers that might cause people to display behaviour that challenges. During the inspection we observed staff supporting people effectively, in line with instructions in their care plans. For example, one person became angry with a staff member when they were trying to support them. The staff member spoke with the person in a calm and friendly way but left the person. They alerted another member of staff who came to see the person. The staff member spoke to the person about something they were interested in. They then asked the person if they could help them. The person agreed.

At our inspection in November 2014, we found people did not always receive effective support through the supervision and appraisal process. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in January 2016, we found action had been taken. Staff felt supported and benefitted from regular one to one meetings with their line manager and an annual appraisal. Supervision gave staff the opportunity to discuss areas of practice. Any issues or poor practice were discussed in supervisions, actions were set and followed up at subsequent supervisions. Staff were given the opportunity to discuss areas of development and identify training needs.

People were not always supported in line with the Mental Capacity Act 2005 (MCA). The 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 told us staff asked for their consent before delivering care tasks and staff were able to describe how they supported people to make choices about their day to day care. However, where care records indicated a person may lack capacity to consent to some aspects of their care, capacity assessments had not been completed and there was no evidence of a best interest decision making process being carried out by professionals and family members. For example, two people had bedrails in place. Although the bedrails had been put in place to keep the person safe from falling out of bed there was no evidence these people had consented to having them in place. There was no evidence of the best interest decision making process being carried out. We also found examples of where family members had consented to peoples care or to having a flu vaccination but capacity assessments had not been carried out to determine if these people were unable to consent to their care in these areas. Staff were not aware that families could not give consent on a person's behalf unless they had legal authority to do so.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Act 2014.

The registered manager understood their responsibilities in relation to the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be restricted of their liberty for their own safety. Where people were thought to lack capacity a local authority DoLS screening checklist had been completed to determine if an application to deprive someone of their liberty needed to be completed. At the time of the inspection no one was subject to a DoLS.

Before this inspection we had received concerns that people were not receiving enough to eat and drink. We observed people were supported and encouraged to eat. However, people were not always given enough to drink. We observed four people who remained in bed during our inspection and needed assistance and encouragement to drink. Although they were assisted with tea or coffee at mealtimes we did not see staff assist them with other fluids such as water or juice at other times during the day. Each person had a drinking jug in their room and we monitored the quantities in this jug throughout the inspection and noted they remained at or near the same level.

People were encouraged to eat and told us they enjoyed the food. Comments included: "Plenty of food. No problems with it", "I eat anything that is put in front of me. Good enjoyable food" and "A lovely lunch today. Food is good here". A relative said, "Can't fault the food here. No complaints".

People were offered a choice of what to eat and drink. Alternatives were available for people who wanted something different from the menu options. People who were given assistance to eat in the dining room were supported in a respectful manner. For example, one person could not see well. The staff member serving their meal described what was on the plate and where on the plate it was. People were supported to be independent with eating their meal. For example, people were provided with finger foods or adapted plates and cutlery.

People's specific dietary needs were met. For example, people received softened foods or thickened fluids where choking was a risk. Where people were at risk of malnutrition, staff took quick and effective action. For example, staff had identified one person who had lost weight. Staff informed the person's GP who had prescribed nutritional supplements. The person was weighed weekly and their food and fluid intake had been monitored. The person had begun to gain the weight they had lost. People received their nutritional supplements as prescribed. Staff were aware of people's cultural requirements in relation to food. For example, people who because of their faith required Halal meat or vegetarian food.

Areas of the service where people were living with dementia were not decorated in a way that followed good practice guidance for helping people to be stimulated and orientated. For example, the service was decorated in neutral tones which could make it difficult for people to differentiate different areas of the home. Whilst there was some art work on the walls there was nothing for people with dementia to engage with. Some people had pictures in a frame by their room door which may help them recognise their room. However, other people's frames still contained the leaflet with instructions on how to use the frame and had not been personalised. We discussed this with the registered manager who told us a specialist in Dementia care was due to visit the service to provide advice on ensuring the environment met the needs of people living with dementia.

People told us they had regular access to other healthcare professionals such as, the GP, chiropodists, opticians and dentists. On the day of the inspection one person who was not feeling well was asked, "Would you like to see the doctor?" Another person had been seen by the GP at the weekend when staff had noticed a change in the person's condition. The GP had visited the same day and prescribed antibiotics. On the day

of the inspection staff thought the person's condition had deteriorated and contacted the persons GP to express their concern and to request another visit. Details of any professional visits were documented in each person's care record, with information on outcomes and changes to treatment if needed. People were referred for specialist advice if required such as, from the occupational therapist, physiotherapist or speech and language therapist. We saw evidence this advice was followed and incorporated into people's care records.

People and their relatives expressed confidence in the ability of the staff. One person told us, "Staff are very good they help me and see that I am alright". A relative said, "No complaints at all. Has been here for 5 years, no pressure sores or any real problems. Staff know what they are doing".

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. For example, training in caring for people who had a specialist feeding tube in their stomach.

Newly appointed care staff went through an induction period. This included training for their role and shadowing an experienced member of staff. The induction plan followed nationally recognised training and standards in the care sector and was designed to help ensure staff were sufficiently skilled to carry out their roles before working independently. One new member of staff told us they had been well supported in their new role and had been allocated a mentor. They said, "My buddy is taking me through what I need to do" and "People (staff) always ask if I'm ok". New staff confirmed they had not been asked to do anything they were not fully trained for. For example, one staff member told us they were due to have a practical session on moving and handling the following day and confirmed that they had not been asked to use any moving and handling equipment during their work.

Requires Improvement

Is the service caring?

Our findings

Most of the interactions we observed during this inspection showed that people were treated with dignity and respect. However, on one unit we observed two interactions where people who were being assisted to eat in their rooms were not supported in a respectful way. For example, a staff member brought a tray of food for one person. They did not greet the person or explain what was on the plate. They assisted the person to eat their meal in silence. Another person being assisted with their meal in their room was only spoken to when the staff member said "Open your mouth". We also observed two staff members on this unit speaking with each other with raised voices, using an angry tone on two occasions. These interactions could be observed and heard by people living in the home and may have been worrying for some people.

People felt cared for and were complimentary about the staff and living at the service. Comments included: "They're very good to me here. I have no complaints and the staff are good", I'm well looked after" and "They're great all these nurses". Relatives described staff as "Lovely caring people", "Very kind", "Always compassionate" and doing a "Magnificent job".

People were treated in a kind and caring way. For example, one person had become unwell during the day. The GP had been contacted and had asked staff to observe the person. After this call we observed a chair was placed beside this persons bed staff took it in turns to sit with them. We observed staff speaking with this person in a soothing way and offering them small sips of water.

People looked well cared for, were clean and tidy in their appearance and dressed appropriately for the weather. A relative told us their family member "Always looked nice". The service had a hairdresser. People who were bed-bound or did not like to leave their room had the opportunity to have their hair done. The hairdresser told us they worked with staff to facilitate this. They said, "People like having their hair done. Over the years I have learnt to wash, cut and set people's hair in bed. It's only fair that everyone can have their hair done. It is an important part of peoples' lives".

People were encouraged by staff to make choices and decisions about their care. For example, throughout the inspection we heard staff asking people where they wanted to spend their time. If people preferred to stay in their room staff asked them if they wanted the television or radio on. Staff described how they helped people to make decisions about their day to day care. One staff member told us, "We always show what clothes choice a resident could have and try to encourage them to pick what they would like to wear".

People were supported to be independent and were encouraged to do as much for themselves as possible. Some people used equipment to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use it. For example, plate guards so they could eat independently and mobility aids.

People were supported with their personal care discreetly and in ways which upheld and promoted their privacy and dignity. For example, staff knocked on people's doors and waited to be invited in before entering and ensured people's curtains and door was closed during care. Staff were knowledgeable about

how people preferred to be supported in relation to their personal care. For example, if people preferred a female or male member of staff to support them. We heard one member of staff ask a person "Would you like a shower, bath or a wash?" The person requested a wash in their room and staff assisted them to do this.

People were able to have visitors when they wanted. Visitors told us they were made welcome and we observed them being warmly greeted when they entered the service. The service regularly hosted family meals and parties for people. We were told how one person's spouse who did not live at the service had passed away. The service arranged and hosted the wake after the service. The chef told us "It's the person's home and they find it difficult to go out so we held it here".

People's equality, diversity and human rights were respected. For example, people told us their religious and spiritual needs were being met. The service employed their own Methodist minister but people told us they were able to see a minister from another faith if they wished. Staff were aware of peoples' spiritual needs and told us they would be prepared to accommodate the needs of people from all faiths.

People were encouraged to play an active role in the service. For example, people were encouraged to join in with the gardening and the minister involved people in preparing the religious services.

Staff understood how people living with dementia may communicate their feelings through their behaviour. When people appeared confused or anxious staff were quick to notice this and offer people support. The services minister spent time with people and gained an understanding their unique ways of expressing themselves. This information was shared with staff and used to inform peoples care. For example, one person often became frustrated and swore at staff. The minister said, "[name of person] was very distressed, swearing at carers. I wanted him to feel valued and not to be so abusive. I found that he liked singing so I brought in a Karaoke machine and if he started swearing I would get him to sing along. Loss of control causes his frustration". We observed a person becoming frustrated and observed staff distracting the person by singing a song. The person joined in the song and smiled at the staff member. When the person appeared calm the staff member took the time to find out why the person had become frustrated. They found out it was because the person had wanted to leave the dining room and sit in the lounge. They assisted the person to sit in the lounge. Throughout the interaction they treated the person in a respectful and caring way.

Requires Improvement

Is the service responsive?

Our findings

Before people came to live at the service, their needs had been assessed to ensure they could be met. People's care records contained detailed information about their life histories, health, social care needs and how to maintain people's independence. Care records reflected how each person wished to receive their care and gave guidance to staff on how best to support people.

Relatives felt they were involved in their relatives care and were confident any changes in the persons needs would be discussed with them if necessary. One relative told us, "I am invited and I do go to some of the meetings about [name of service user]. I think that they do listen to what you say". On the day of the inspection we observed a review of one person's care taking place. The person, their relatives, staff and a visiting social care professional met at the service to talk about the persons care needs. We spoke with the social care professional following the meeting and they told us "Staff do their best to support people in the way they want to be supported".

People knew how to make a complaint and the provider had a complaints policy in place. One relative said, "Things that we have had to speak about have been sorted out quickly and staff let us know what they have done about it". There had been nine written and verbal complaints since our last inspection and 22 written compliments. The registered manager had responded to the complaints in line with the provider's policy on handling complaints. Any concerns were investigated and recorded. The registered manager discussed concerns with staff individually and more widely at team meetings to ensure there was learning and to prevent similar incidences occurring. The registered manager kept a log of any verbal issues or concerns received together with the action that had been taken. This showed action had been taken promptly to address the concerns.

People were able to pursue activities and interests that were important to them. For example, people and their relatives were involved in a choir that had been formed by the services minister. In November they had recorded a CD of bygone songs. People told us how much they had enjoyed doing this. One relative said "We were involved with making the CD. [Name of person] loved being involved. It gives him purpose". The service had two activities staff who helped people take part in a range of activities. For example, trips to local places of interest, quizzes, entertainers, pet therapy and chair based exercises. However, some activities were not organised in a way that benefitted people living with dementia. For example, in one lounge on the unit for people living with dementia the activities coordinator put out dominoes, magazines and some books on the table. They then went to deliver an organised activity on another unit. Staff did not support people to access these activities and they remained unused. People in their rooms did not always benefit from the same level of interaction or activities as people in communal areas. We were told the activities coordinator and minister usually visited people in their rooms. On the day of the inspection we observed activities staff engaged in one to one activity with people in communal areas; we did not see them visit people in their rooms. We also observed many missed opportunities for interaction when staff walked past people's rooms without going in to speak with them unless they were involved in providing a care task.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in November 2014, we identified there was not an effective system to assess and monitor the quality of the service and to identify, assess and manage risks relating to the health, welfare and safety of people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in January 2016 we found action had been taken. There were a range of quality monitoring systems in place to review the care and treatment offered by the service. These included a range of clinical and health and safety audits carried out by the area management team, registered manager and clinical leads. These had identified some of the issues we found during the inspection. There was a plan in place to address them but some of the actions had not yet been started and improvements had not all been sustained or embedded.

Staff were not always supported to improve the quality of care they delivered through effective leadership. Care staff were directly supervised by nursing staff. Although care staff knew people well, some nursing staff were unfamiliar with people's needs and when we asked specific information they were vague about how people should be supported. There was poor communication between nursing and care staff which led to some confusion in the delegation of tasks. For example, who had responsibility for instigating interventions such as positional changes or food and fluid monitoring charts.

The service had a registered manager. They were being supported by a deputy manager, clinical lead and an area manager. People and their Relatives referred to the management team as being open, approachable and friendly. The manager had an open door policy and was visible around the service. One relative said, "We feel confident to ask staff to deal with any concerns or speak to management". A visiting professional described the registered manager an "Open and responsive" and confirmed their door was always 'open' to people and their families.

Staff described a culture that was open. Staff were confident the management team would support them if they used the whistleblowing policy. Staff felt supported and told us there had been improvements at the service recently. One staff member said, "Staff morale has got better. We are a team and we all work together". There were regular staff meetings and staff felt able to make suggestions to improve people's care or the service.

There was a procedure for recording incidents and accidents. Any accidents or incidents relating to people who used the service were documented on a standardised form and actions were recorded. The registered manager checked and audited the forms to identify any risks or what changes might be required to make improvements for people who used the service. For example, the registered manager had noted that one person frequently fell when getting up from their chair. Once they were up they were able to mobilise without assistance. The person did not always remember to call staff when they wished to get up. A chair sensor was purchased which alerted staff if the person began to get up so that they could be offered assistance. Since the sensor had been put into place the persons incidence of falls had significantly reduced. Accidents and incidents were also discussed during team meetings and during staff supervision to ensure

lessons were learnt and to prevent similar incidences occurring.

People were actively encouraged to provide feedback through a satisfaction survey and meetings. The registered manager held six monthly meetings for people and their relatives. People told us they had been able to offer their views and suggestions about the running of the service. Minutes of the meetings were kept together with plans that demonstrated action was being taken as a result of any suggestions and feedback. For example, some feedback had been received about the menu choices. Some people said they would like to see more traditional dishes on the menu. The menu was changed and the registered manager completed observations in the dining rooms so they could observe how people who could not give feedback verbally seemed to enjoy the new menus. People were positive about the changes and the service noticed that people who had previously lost weight were beginning to gain weight.

We recommend that the service seek support and training, for the nursing team, about leadership.

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	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not understand their responsibilities under the Mental Capacity Act 2005 (MCA) because they were not clear about the action they must take if the person did not have capacity to consent to their care. Regulation 11 (1) (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safe and proper management of medicines. Regulation 12 (1) (2) (g).

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person did not always take proper steps to mitigate the risks associated with peoples care. Regulation 12 (1) (2) (a) (b).

The enforcement action we took:

We have issued a warning notice to the Provider and the Registered Manager.Warning Notice