Methodist Homes

Brookfield

Inspection report

Little Bury
Oxford
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this service on 23 May 2016. This was an unannounced focused inspection.

We had previously carried out an unannounced comprehensive inspection of this service on 20 January 2016 and found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One of the breaches was in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always protected from the risks associated with their care and treatment in relation to pressure ulcers. We also found people were not always protected against the risk of falls because they did not have a call bell within reach. As a result of this breach and the impact this had on people who lived at Brookfield, we rated the key question of 'Safe' as inadequate. We issued a warning notice telling the provider they must make improvements to meet the legal requirements in these areas by 5 April 2016. We undertook this inspection to check the service had made these improvements.

This inspection and report only covers our findings in relation to the prevention and treatment of pressure ulcers and the risk of falls if people did not have access to a call bell. We did not look at the whole key question relating to 'Safe'. We will review this during our next planned comprehensive inspection of the service. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brookfield on our website at www.cqc.org.uk

There was a registered manager in post. 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 provider and registered manager had improved the system for the prevention and treatment of pressure ulcers. All staff had received training in this area. People's care plans had been reviewed and contained detailed risk assessments. Where risks were identified there were management plans in place to mitigate the risk. Staff followed the plans and completed monitoring charts to record how people's position was being changed to reduce the risk of pressure ulcers. These were up to date and there was a record of the staff input and care being carried out.

People had call bells in reach. Call bells were answered promptly and people were offered assistance in a timely way. Some people were unable to use a call bell. Staff had identified the risks to people who were unable to use the call bell. Care plans included details of how those risks would be managed and staff followed the care plans to ensure people were safe.

Staff had a better understanding of people's needs. Communication between nursing and care staff had improved and they were working more effectively as a team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Action had been taken to improve the safety of people using the service.

People received safe care in relation to the prevention and treatment of pressure ulcers.

People had call bells within reach.

We have improved the rating for this key question from inadequate to requires improvement; to improve the rating to good requires consistent good practice over time. We will check for further and sustained improvement at our next planned comprehensive inspection.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection on 23 May 2016. This inspection was carried out to check improvements had been made by the provider after our comprehensive inspection on the 20 January 2016. This inspection looked at one of the key questions we ask about services: is the service safe. This was because the service was not meeting all of its legal requirements at the January 2016 inspection.

This inspection was undertaken by one inspector.

We looked at six people's records. We spoke with four care staff, one nurse, the deputy manager, the registered manager and the area support manager.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection in January 2016 we found the provider had not ensured care was provided in a safe way for service users or was doing all that was reasonably practicable to mitigate risks to people's health and safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action advising the provider they must make improvements to meet the legal requirements by 5 April 2016. At this inspection in May 2016 we found the required improvements had been made.

At our inspection in January 2016, we found people were not always protected from the risks associated with their care and treatment in relation to the prevention and treatment of pressure ulcers. Pressure ulcers are also sometimes known as 'bedsores' or 'pressure sores'. They are caused when an area of skin is placed under pressure which breaks down the skin and underlying tissue. 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.

At this inspection in May 2016, we found people received safe care in relation to the prevention of pressure ulcers. All staff had received refresher training in pressure ulcer care. We looked at the care records for people who had been identified as at risk of developing pressure ulcers. Nursing staff had reviewed the care of each person. Where the person was unable to move around on their own they had pressure relieving equipment and repositioning charts in place. We observed people had their position changed in line with the frequency stated on their charts and this had been recorded. Staff were able to tell us the frequency of each person's repositioning schedule and why it was important for people's position to be changed.

There was currently one person at the service with a pressure ulcer. They had been admitted to the service with two pressure ulcers. Nursing staff monitored the wounds and took weekly photographs to show progress of healing and for staff to determine whether the plan of care was effective. Records of each dressing change were made, with details of the condition and size of the wound. When needed specialist health care professionals had been involved in advising staff about suitable dressings to use to promote healing. One of the person's pressure ulcers had healed.

At the inspection in January 2016 we found people were not always protected from the risks associated with falling because they did not have a call bell within reach. At this focused inspection in May 2016 we found there were systems to ensure people had their call bell in reach. Mobile pendant call bells had been provided so people would not be restricted to sitting near where the call bell was plugged into the wall. This also meant people could access the garden or communal areas of the service but still call for assistance if required.

Where people were not able to use a call bell, staff had identified the risks associated with not having a call bell for each person and there was a plan in place for managing those risks. For example, staff undertook half hourly checks on people in their rooms to check all was well or if they needed anything. During this

inspection we heard call bells being answered promptly and saw sufficient staff in close proximity to people to be able to meet their needs in a timely way.

At the inspection in January 2016 we found people had not always received safe care and treatment because there was poor communication between nursing and care staff. Staff told us there was now better teamwork and communication. We observed a lot more communication between staff members. Nursing staff had received training and support to develop their leadership skills. Care staff were now being directed and supervised by the nursing staff. Care staff had been given the responsibility of completing the daily care records including filling in repositioning records and these were checked by the nurse. Care staff were responsible for the care of specific people during their shift. Giving staff new responsibilities had improved the standards of care given. Staff were motivated to deliver high standards of care and the atmosphere within the service was friendly and happy. Staff told us the improvements that had been made to the service had led to them now being clear about their roles and responsibilities in ensuring people were kept safe.