Four Seasons (H2) Limited

The Headington Care Home

Inspection report

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Date of inspection visit:
27 January 2016

Date of publication:
21 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 27 January 2016. This was an unannounced inspection. The Headington Care home is registered to provide accommodation for up to 60 older people living with dementia who require personal care. At the time of the inspection there were 58 people living at the service.

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 registered manager worked closely with the area manager.

People who were supported by the service felt safe. The staff had a clear understanding on how to safeguard the people and protect their health and well-being. There were systems in place to manage safe administration and storage of medicines. There were enough suitably qualified and experienced staff to meet people needs. However, staff were not always deployed effectively. People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where required, staff involved a range of other professionals in people's care. Staff were quick to identify and alert other professionals when people's needs changed.

People received care from staff who understood their needs. Staff received adequate training and support to carry out their roles effectively. Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People were supported to have their nutritional needs met, however, the dining experience varied. People were not always given choices and some did not receive their meals on time. We observed people during lunch time and saw people being supported with meals.

There was a calm, warm and friendly atmosphere at the service. Every member of staff we spoke with was motivated and inspired to give kind and compassionate care. Staff knew the people they cared for and what was important to them. Staff appreciated people's unique life histories and understood how these could influence the way people wanted to be cared for. People's choices and wishes were respected and recorded in their care records.

People did not always have access to activities and stimulation from staff in the home. Activities were not always structured to people's interests. Relatives told us there wasn't always much to do. However, other people told us they were happy. We discussed these concerns with the registered manager, deputy manager and area manager who informed us a new activity co-ordinator's post had been advertised, and staff were to receive coaching on dementia care and activities.

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way. Staff had also identified they needed more training in this area and the manager was arranging it.

People felt supported by competent staff. Staff benefitted from regular supervision (one to one meetings with their line manager) and team meetings to help them meet the needs of the people they were caring for.

The manager informed us of all notifiable incidents. The service had good quality assurances in place, however, these were not always used effectively. The manager had a clear plan to develop and improve the home. Staff spoke positively about the management and direction they had from the manager. The service had systems to enable people to provide feedback on the support they received.

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?

Good

The service was safe.

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

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

Arrangements for medicines were in place to ensure they were administered safely and stored appropriately by staff

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to have their nutritional needs met, however, the dining experience varied.

Staff had the knowledge and skills to meet people's needs

Staff received training and support to enable them to meet people's needs.

People who were being deprived of their liberty were being cared for in the least restrictive way. Staff had good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to access healthcare support when needed

Is the service caring?

Good

The service was caring.

People were supported by caring staff who treated them with dignity and respect.

Visitors to the service and visiting professionals spoke highly of the staff and the care delivered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive activities or stimulation which met their needs or preferences.

People's care plans were current and reflected their needs. However, some of them were not always complete.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to monitor the quality and safety of the service and drive improvement. However, these were not always used effectively

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

The leadership throughout the service created a culture of openness that made people feel included and well supported.

The Headington Care Home

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 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 27 January 2016 and was unannounced. The inspection team consisted of three inspectors and a specialist advisor in dementia.
Before the inspection we reviewed the information we held about the service and the service provider. The registered provider 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 received feedback from four healthcare professionals who regularly visited people living in the home. These professionals included a GP, a falls specialist, a specialist in adult psychiatry and social worker. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

We spoke with six people and seven relatives. We looked at twelve people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the manager, the area manager and eleven staff which included nursing, caring, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We reviewed feedback from people who had used the service and their relatives

Good

Is the service safe?

Our findings

People told us they felt safe and supported by staff. One person told us "Yes I feel safe". Another one said "I am safe here. I like it". Relatives told us they felt the service was safe. Comments included, "I feel safe to leave my mum as the care team know her well and how to care for them", "I know my mum is safe as they (staff) know her little ways" and "I can go home every day knowing my dad is safe here".

Staff were knowledgeable about the procedures in place to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding and whistleblowing procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly.

Risks to people's safety had been assessed and people had plans in place to minimise the risks. One professional commented, "Considering the challenges that some of their clients pose, they (the manager) provide an excellent environment for the residents. The risk assessments are usually up to date and they (the provider) are well aware about safety of their residents and staff". Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person had unprovoked behaviour that challenged and could have posed a risk to themselves and others. We saw they had comprehensive risk assessments in place that resulted in the provision of one to one care. Another person smoked. We also saw staff supported this person to smoke safely throughout the day in a designated area. The person had a detailed risk assessment in place to allow safe staff support.

Staff were aware of the risks to people and used the risk assessments to inform care delivery and to support people to be independent. Risk assessments included areas such as falls, weight loss, challenging behaviour and moving and handling. Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home.

People were supported by sufficient staff with the skills and knowledge to meet their individual needs. Staffing levels were determined by the people's needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The manager considered staff sickness levels and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels. One professional told us, "Staff levels seem to be fairly stable on the whole, which facilitates our working relationship". Staff rotas showed the manager always had enough staff on duty and had no use of agency staff. This ensured consistence in people's care from staff that they knew.

Safe recruitment procedures were followed before staff were appointed to work at The Headington care home. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

Medicines were stored and administered safely. We saw people received their medicines when they needed them. We observed staff administered medicines to people in line with their prescriptions. Where people had limited capacity to make decisions about their own treatment, the service did not always follow the correct procedures when medicines needed to be given to people without their consent. For example, one care record did not state how the covert medicines were to be given. We discussed this with the manager who said this would be rectified as a matter of urgency and that it could be a matter of information not being carried forward. 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.

Equipment used to support people's care was clean and had been serviced in line with national recommendations. Where people had bedrails to reduce the risk of falling out of bed, checks were conducted by maintenance staff and night staff. Records showed risk assessments and consent documents had been completed for the use of bedrails. We observed staff using equipment correctly to keep people safe.

Staff understood their role and responsibilities for maintaining standards of cleanliness and hygiene. One member of staff said, "We wash our hands before serving meals". Another one said, "We wear aprons and gloves and wash our hands afterwards to prevent spread of infection". We observed staff washing hands appropriately and wore aprons when they served meals. Infection control was embedded in the service's mandatory training with yearly updates.

Requires Improvement

Is the service effective?

Our findings

We observed people's lunchtime experience and in particular those who were living with dementia. The dining experience was varied and there were inconsistence practices. For example, in two out of the four dining rooms we saw staff did not show people the lunchtime meal option visually. This assists people with dementia to make a choice as some were not able to verbally understand the choices available to them without visual stimulation. Where people needed assistance with their food, the support differed from dining room to dining room. We saw people who were sitting at the dining table did not receive their lunch for nearly an hour after sitting down despite others on the table being assisted to eat their lunch, this included drinks. There was inconsistent support given to people in different dining rooms during meal times which resulted in some people not enjoying the dining experience. Although there were enough staff overall to help people during meal times, they were not always deployed effectively. We raised this with the manager and area manager, they told us they had recognised this and they would review the deployment of staff during meal times.

These concerns were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with felt staff were skilled enough to meet people's needs. One relative told us, "Staff know what they are doing. They are very patient". Another one complimented, "Staff are very good with my wife. They know how to look after her".

People's specific dietary needs were met. Kitchen and care staff had the information they needed to support people. Some people had special dietary needs, and preferences. For example, people having softened foods or thickened fluids where choking was a risk. Where some people had lost weight there was a plan in place to manage weight loss. The home contacted GP's, dieticians and speech and language therapists if they had concerns over people's nutritional needs. One person had been referred to speech and language therapists for guidance and this guidance was being followed. Records showed people's weight was maintained. We observed snacks were available for people throughout the day, such as fruit, cakes and biscuits. Staff were aware of how much fluid people needed on a daily basis and their daily intake was recorded.

We observed one member of care staff who supported a person to eat their meal which was in line with their care plan. The member of staff worked at the person's pace and let the person assist themselves as much as possible. This showed us that the staff understood the needs of people they supported. We saw some good practice, for example one member of staff came to support another person eat their main course when other people on the table were already having dessert. We saw they apologised for keeping the person waiting and asked if it was alright to use a napkin.

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were safe and sufficiently skilled to carry

out their roles before working independently. Staff comments included, "I had one week induction which was very good", "Induction was very good, and I learnt a lot" and "Induction included dementia awareness training and shadowing afterwards".

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling, safeguarding and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. For example, training in dementia care. One staff member told us, "It is very important to receive training in dementia care as all the people we look after have some form of dementia". Another one said, "Dementia training made me see that people can live their lives like before". Staff told us they had the training to meet people's needs. We observed staff were aware of people's needs and had identified the need for more training in end of life care. The manager told us this was being arranged for all staff across the board.

Staff were supported to improve the quality of care they delivered to people through supervision (one to one meeting with their line manager) and annual appraisal. Staff comments included, "We have supervision every two months and yearly appraisals", "Yearly appraisals, we talk with the manager and she asks me if I am happy" and "We have several supervisions in a year. We talk about how we do our job and review the way we do care plans". Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervisions. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans formed part of the annual appraisal process. Records showed staff had requested more dementia training and this had been provided.

People had regular access to other healthcare professionals such as, chiropodists, opticians and dentists. People were referred for other specialist advice. For example, from the speech and language therapist (SALT) if they were thought to be at risk of choking or the falls team for issues with mobility. We saw evidence that specialist advice was followed. Professionals told us they were notified of people's changing needs. One professional commented, "They (provider) have been responsive to recommendations by our team. For example, around the care planning or interventions for people". People had 'hospital passports' to allow information sharing when they were admitted to hospital. This was a prepared document which had all the necessary information ready for any person going into hospital including past medical history and any medicines the person was taking.

People could move around freely in the communal areas of the building and gardens. There were several sitting rooms, the music room and garden areas, which gave people a choice of where to spend their time. Most of the home's areas were decorated in a way that followed good practice guidance for helping people with dementia to be stimulated and orientated. However, this was not consistently applied in all areas. For example, some communal bathrooms did not have contrasting colour toilet seats to aid location. The menu boards were small and had a lot of information but no pictorial enhancement which is useful to people living with dementia. We discussed these concerns with the manager and they said assured us this would be addressed.

People's consent was always sought before any care or treatment was given. We observed staff knocking on people's doors and seeking verbal consent whenever they offered care interventions.
We also saw in care files that people, or family members on their behalf, gave consent for care they received and in line with best interest decision making guidance. For example, all files reviewed showed consent for taking and using photographs.

Staff were aware of their responsibilities under the Mental Capacity Act 2005(MCA). The MCA provides a legal

framework to assess people's capacity to make certain decisions at a certain time. Records showed staff knowledge on MCA was often tested by the manager during appraisals and reviews. People were always asked to give their consent to their care, treatment and support. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity, there was evidence of decisions being made on their behalf by those who were legally authorised to do so and were in the person's best interests. We spoke to an advocate who visited the home regularly. They told us, "If they raised any issues, these were always responded to positively and addressed quickly".

Staff had a good understanding of their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. People who lived under DoLS were being supported effectively and the DoLS were specific to the person's restriction. For example, people had DoLS for covert medicines, not leaving the home, decisions around health and decisions around resuscitation. Most people were under DoLS as they were not able to leave the home unsupervised and were under continuous supervision. Staff ensured these people were supervised and took them to the home's lounge every day to ensure they were being stimulated. For example, people interacted with others under supervision and were encouraged to assist in simple tasks like setting up dining tables. The people's care records showed this had a positive impact on their daily life.

Good

Is the service caring?

Our findings

Most people in the home could not speak verbally to us because of their condition. However, the few that spoke to us were positive about the care they received. One person said, "Good place to live. Staff alright". Another one commented, "Staff very friendly. Yes caring". Relatives also spoke positively about the home and the care their relatives received. One relative told us, "Excellent. Care is unbelievable". We also received many positive comments from other professionals. Comments included, "They (staff) have a caring attitude without being patronising", "If I had a relative with severe dementia, I would definitely consider The Headington care home for placement" and "I think they (staff) do an amazing job with very challenging clients and have a positive attitude".

We observed many caring interactions between staff and the people they were supporting during our inspection. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm and pleasant. There was chatting and appropriate use of humour throughout the day.

Staff told us they were caring. One member of staff said, "We do the best for people and take care of them. I treat them like they are my grandparents". Another one told us, "People are unique. I am really happy to look after them". People recognised care workers and responded to them with smiles which showed they felt comfortable in their company. Staff took time with people. Tasks were not rushed and they worked at the person's own pace. One professional told us, "Staff always appear caring and attentive to client's (people's) needs".

Staff showed they cared for people by attending to them in a caring manner. We observed people being assisted at lunch time. For example, staff sat at eye level whilst assisting people to eat and appeared engaged in this activity making eye contact and not rushing these people. Another person was distressed and a member of staff came up to the person. They talked with the person and asked how they were. They gave time for the person to talk and held the person's hand. However, this experience was not shared by all the people in the home. These concerns were raised with the manager who said they would review the lunch time experience for people.

Staff were aware of people's unique ways of communicating. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. For example, one member of staff told us about a person who was not usually vocal, they knew that if they were shouting this meant they were in pain.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. For example, staff told us how they treated people with dignity and respect. One member of staff said, "We always close curtains and doors before giving personal care". Another one said, "We do personal care in bedrooms or bathrooms with doors closed".

Staff understood and respected confidentiality. One member of staff told us, "We do not talk about clients in public places". Another one commented, "Client's information is confidential and we keep that private. We saw records were kept in locked offices only accessible using a keypad.

People were involved in decisions about their end of life care and this was recorded in their care plans. For example, one person had a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw the person and their family were involved in this decision. Another person had 'Wishes to be resuscitated' on the front of their records. People, their families and professionals contributed to the plan of care so that staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life. Relatives told us end of life care was provided in a compassionate and supportive way. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. They talked about how they would maintain people's dignity and comfort and involve specialist nurses in the persons care. One member of staff said, "If a person is end of life, we support them with regular attendance and include family".

Requires Improvement

Is the service responsive?

Our findings

The provider had an activities coordinator. However, they had not had any formal training for activities suitable for people living with dementia. The coordinator's knowledge on dementia was limited. This resulted in people not receiving structured activities to meet their individual needs. We discussed these concerns with the manager. They informed us that they were aware of the concerns and were in the process of looking to employ a trained activities coordinator to ensure people received and had access to activities which were important to them. The manager said, "Recruitment has been hard as I need the right skills and motivation for this role". On the day of the inspection there were limited organised activities available for people, especially those with dementia.

Staff did not always engage with people in a meaningful way. We observed staff spent time with people throughout our inspection. In all the lounges a staff member was always present. However, a number of people in these lounges were left without engagement from staff which resulted in them falling asleep even though staff were present. We asked one member of staff how the team interacted with people when the activities coordinator was not in the room and they said, "We play music and give them (people) something to look at. We don't interact with them in the morning as we have to get everyone up. In the afternoon staff browse through a magazine with them". Some of the people had family pictures in front of them but not much interaction from staff. One relative was not happy that a person's pictures had been brought out of their bedroom and displayed in front of them. They commented, "Normally no photos are put in front of [person]. [Person] prefers them in their room". One person's record showed no evidence of them having received any activities except watching television and visits by relatives in the last four weeks. One relative commented on the lack of activity provision in the home.

These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were unable to leave their rooms were protected from the risk of social isolation. For example, one person was unwell and remained in bed. We observed staff regularly visited this person in their room to see if they needed anything and took the time to chat to the person and offer food and drink.
Before people came to live at the home their needs had been assessed to ensure they could be met. The manager personally visited people in their place of residence or hospital to perform the assessments. These assessments were used to create a person centred plan of care which included people's preferences, choices, needs, interests and rights. One professional said, "The manager personally assesses every potential new resident and looks into the entire past psycho-social history, talks to families and staff when appropriate".

Care planning was focussed on a person's whole life, including their goals skills and abilities. The provider used a 'My choice, my community' document which captured people's life histories including past work and social life allowing staff to plan person centred care using people's preferences and interests. People's care records contained detailed information about their health, social care and spiritual needs. They reflected how each person wished to receive their care and support. For example, whether people preferred to get up

early or a little later. People and relatives confirmed they were involved in the planning and review of their care. One professional told us, "The complexity of their (provider) work is extraordinary and every resident is treated as an individual. The commitments they have towards their clients and families is commendable". The provider had a key worker system in place which gave people and relatives a point of contact, allowing consistency and the establishing of meaningful relationships.

Records showed staff treated details of what was important to each person living at The Headington care home as important information. For example, staff had recorded information about people's family life, employment and religious beliefs using the 'My choices' document. People's preferences regarding their daily care and support were recorded. This information was used to engage with people and they received their care in their preferred way. For example one record stated, "I get distracted easily and require prompting during meals". This was actioned as we saw staff prompted this person during their meal. Another record showed a person who was forgetful. It stated, "Needs daily orientation and reassurances". We observed staff reassuring the person throughout our inspection.

Risk assessments were regularly reviewed, however actions needed following the review was not always clear. For example, we saw a person had comprehensive risk assessments to follow when their behaviour became challenging. The actions had not been followed and there was no specific behavioural management care plan for staff to follow. However, staff knew this person well and had developed their own coping strategies but these strategies had not been recorded in the person's care plan. This could lead to inconsistencies in managing their behaviour, confusing the person and potentially worsening their behaviour and putting others at risk. We observed staff supported this person sensitively, allowed them to move around safely and offered them activities to distract and engage them appropriately. We spoke to the manager about this and they told us were making a clear behavioural management plan for this person.

Care plans were reviewed monthly to reflect people's changing needs. Where a person's need had changed, the care plan had been updated to reflect these changes. Records showed where appropriate, people signed documents in their care plan which showed they wished to be involved. Relatives told us they had been involved in developing care plans and reviewing care. One relative said, "Yes we get updated on changes and we do care reviews with the nurses". A professional was complementary about care records. They said, "Headington have very comprehensive and well maintained care plans. This is reflected when we come to review the care plans".

Staff completed other records that supported the delivery of care. For example, food and fluid charts and charts to record how people's position was being changed to reduce the risk of pressure sores. These were up to date and there was a clear record of the staff input and care being carried out.

Feedback was sought from people through regular relatives and residents meetings as well as quality assurance surveys. Records showed that some of the discussions were around the provision of more activities and food choices. For example, people and relatives had suggested the chef prepared meal options to show people during meal times and this had been followed through.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on the service's notice boards. Relatives commented that the manager "Was visible, easy to get hold of and was responsive to concerns". Staff were clear about their responsibility and the action they would take if people made a complaint. Records showed complaints raised had been responded to sympathetically, followed up to ensure actions completed and any lessons learnt recorded. For example, a complaint had resulted in a person being offered a meeting to discuss concerns and the manager had offered a change of room or unit as a solution. People spoke about an open

culture and felt that the home was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Requires Improvement

Is the service well-led?

Our findings

The service was led by the provider and a manager who had good support from a deputy manager. The manager had been in post for eight years. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

There was a clear procedure for recording accidents and incidents. Any accidents or incidents relating to people who used the service were documented, however, actions were not always followed through. For example, one person with unpredictable behaviour had several incidents involving staff but there were no specific action plans to reduce the chance of further incidents occurring. As a result more incidents had occurred. We spoke with staff and they told us they had developed consistent strategies to support the person. The manager told us they would update this person's care plan and would ensure all staff were aware of how to manage this person safely. The manager told us they had made a referral to the community mental health team. Incident forms were checked and audited to identify any trends and risks or what changes might be required to make improvements for people who used the service but they were not always actioned.

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. The provider had good quality assurance systems in place to assess and monitor the quality of service provision but these were not always used effectively. For example, quality audits including medicine safety, environmental safety, care plans and levels of residents need. These audits had identified areas of improvements across a number of areas of care. However, records showed some incomplete care plans but these had not been picked up during care plan audits. The manager was also in the process of reviewing the staff deployment at mealtimes, but this had not been actioned at the time of our inspection.

Feedback received from health and social care professionals praised the level of service offered to people, their relationship with the manager and how well the management and staff team communicated with them. Comments included, "The manager has a strong but personable management style. She is very visible in the home", "Good management and they manage to retain staff considering their clientele" and "Headington is one of the few care homes in the whole of Oxfordshire who we have full confidence in caring for those clients who pose a significant risk to themselves".

The manager had an open door policy, was always visible around the home and regularly worked alongside staff to deliver care. People, their relatives and other visitors were encouraged to provide feedback about the quality of the service. For example, residents and relatives meetings were held regularly, there was an electronic feedback system where comments were welcomed and could be named or anonymised and people and relatives could drop in anytime to speak with the manager.

Quality assurance questionnaires were sent out regularly and given to visitors who came to the home. Feedback and results were audited to ensure any required improvements could be made promptly. The manager told us they were committed to making improvements and any complaints, concerns or feedback

was seen as constructive criticism, with opportunities to learn from them. The manager said, "I have been here for eight years but there is still lots more to do". The provider defined quality from the perspective of people using the service, relatives, staff and any external visitors. Records showed questionnaire feedback from people, relatives and staff. These had identified areas of concern and actions that had been planned as well as outcomes.

Staff described a culture that was open with good communication systems in place. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. Staff told us, "We do handover at the end of every shift and have regular staff meetings", "Manager is approachable and I feel supported by them" and "We have weekly update staff meetings". The manager complimented the staff, "Staff make this a good home. They are committed and aware of improvements to be made.

The provider maintained strong links with the local community. The manager told us they were, "Aligned with a friendship group Friends of Horspaths and a local knitting group". They also had links with Oxford Brookes University who were sending student nurses for work experience.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive activities, stimulation or engagement which met their needs or preferences. Staff did not always engage with people and ensure care was person centred. Regulation 9 (1)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always deployed effectively during meal times.