Bupa Care Homes (CFHCare) Limited

Broadoak Manor Nursing Home

Inspection report

Mulcrow Close
Parr
St Helens
Merseyside
WA9 1HB
Tel: 01744 615626
Website: legalcareservices@bupa.com

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Ratings

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

Overall summary

This was an unannounced inspection, carried out on 06 May 2015.

Broadoak Manor is situated in a residential area of St Helens with access to local buses. There are four units on the one site providing care and support to people. The service is owned by BUPA who provide a variety of health and social care services throughout the country.

The service has 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.

Summary of findings

At the time of our inspection there were 97 people living at the service.

We carried out an inspection of Broadoak Manor in August 2014 and found that the service was not meeting the regulations we inspected. We took action against the provider which included setting a timescale to make improvements in relation to three regulations. We gave compliance actions in relation to two other regulations.

We carried out a further inspection in December 2014 to check on the progress in relation to the regulations we set timescales for and found they had been met. During this inspection we followed up on the compliance actions we gave the provider in August 2014 and found they had been met.

People who used the service felt safe. Staff had received safeguarding training and had access to safeguarding procedures. Staff knew about the procedures in place to protect people from the risk of harm and they knew how to recognise and respond to abuse correctly. The correct procedures had been followed when abuse was suspected or occurred.

People's care and support needs were assessed and planned for. Regular reviews involving people who used the service and significant others ensured staff had all the information they needed to meet people's current and changing needs. People's care records accurately reflected their care and support needs and the care and support they had received.

People's needs were met by sufficient numbers of staff. Recruitment procedures were safe and staff had received ongoing training and support to ensure they carried out their role effectively.

Medicines were managed safely and processes in place ensured that the administration and handling of medicines was suitable for the people who used the service.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We saw that there were policies and procedures in relation to the MCA and DoLS to ensure that people who could make decisions for themselves were protected. Where people lacked the capacity to make decisions about something, best interest meetings were held and documented in people's care records.

People were offered a varied and healthy diet and people told us they had enough to eat and drink. People received the assistance they needed at meal times and those who were at risk of poor nourishment were closely monitored.

Staff were kind, caring and patient in their approach. Staff knew people well and formed good relationships with them and their family members.

The provider supported and encouraged learning and the staff team had the required skills and knowledge to care for the diverse and complex needs of the people who used the service.

People's interests and hobbies were recorded and they were offered a range of indoor activities. However people commented that there had not been given the opportunity to access the community and it was something they would like to do.

People were made aware of how to make a complaint if required and complaints were listened to and acted upon in a timely way.

People described the manager as supportive and approachable and they felt that the service was well managed. There were systems in place to regularly check the quality of the service provided and to ensure improvements to the service were made.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff knew how to recognise and report abuse and potential abuse.

There were sufficient staff on duty to meet people's needs. Safe recruitment procedures were thorough and safe.

Medication was managed safely and people received their prescribed medication at the correct time.

Good

Is the service effective?
The service was effective.

Staff received training and support which enabled them to carry out their roles effectively. Staff had good relationships with other professionals and requested advice and support from them in relation to people's care and support.

Staff demonstrated they had an awareness and knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), which meant they could support people to make choices and decisions where people did not have capacity.

People were provided with a choice of food and drinks and they received the support they needed to eat and drink.

Good

Is the service caring?
The service was caring.

Staff took time to listen to people and people's wishes were respected.

People were treated with kindness and compassion and their wishes were respected. Staff reassured and comforted people when they were upset or anxious.

Systems were in place to ensure staff had all the information they needed to meet people's assessed needs.

Good

Is the service responsive?
The service was responsive.

Where possible people were asked about their care and how they wished it to be provided.

People had a care plan for their assessed needs and they received the right care and support.

People knew about how to complain and were confident about complaining if they needed to.

Good

Is the service well-led?
The service was well led.

Staff were clear about the leadership of the service and their roles and responsibilities.

Good

Summary of findings

The provider had systems in place to assess and manage any risks to people's health safety and welfare.

Staff were positive about the leadership of the service and felt able to raise any concerns they had with the registered manager.

Broadoak Manor Nursing 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.

We visited the service on 06 May 2015. Our inspection was unannounced and the inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal or professional experience of using this type of service.

During our inspection we spoke with 18 people who used the service and seven family members. We also spoke with the registered manager, 12 care staff, six ancillary staff including the cook, kitchen assistant and laundry staff. We observed care and support in communal areas, looked at the care records of eight people and records that related to how the service was managed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection. We contacted local commissioners of the service, GPs and district nursing teams who supported some people who used the service to obtain their views about it.

Good

Is the service safe?

Our findings

At our last inspection in August 2014 we were concerned because people who used the service were not protected from abuse or the risk of abuse because the provider did not respond appropriately when it was suspected that abuse had occurred. The provider sent us an action plan outlining how they would make improvements. At this visit we found the required improvements had been made.

People told us they felt safe living at the service and that there was mostly enough staff around to help them. People said they received all their medication at the right times. People's comments included; "I am safe here because everything is ok. I'd tell the nurse if anything wasn't ok and she'd sort it out for me", "I feel safe here because there's people around me", "I never feel I have to wait for staff. There's always staff around", "I get my medicines on time", "There's enough staff here but sometimes they are busy and I have to wait" "I can ask and get a painkiller. "I get the help when I need it". Family members commented; "She is safe here" "She does get her medicines on time" and "There's enough staff here".

The service had an effective safeguarding and whistleblowing process to support people safely.

Staff had completed up to date safeguarding training and they had access to the providers and the relevant local authorities safeguarding procedures. Staff understood what their responsibilities were for keeping people safe from abuse and for reporting any concerns they had. Staff knew the different types of abuse and signs which indicate abuse may have taken place, including unexplained bruises and a change in people's mood or personality. Staff comments included; "I wouldn't think twice about reporting abuse" and "Definitely, I'd report it right away to the person in charge". The information we held about the service showed that staff had correctly reported any concerns of potential abuse. The registered manager responded appropriately to information of concern and reported to the relevant authorities when required. Records showed that the providers and the local authorities' policies and procedures had been followed correctly.

Risk assessments had been carried out and were regularly reviewed in relation to people's care and support needs, such as personal safety, skin integrity, falls, manual handling and nutrition. Care plans incorporated risks which people faced and detailed the action staff needed to take to ensure people's safety. Staff were aware of their responsibility to keep people safe and to report any changes which they considered would have an impact on people's safety. We observed staff using equipment to support and move people safely in accordance with their risk assessments. Each person had a personal emergency evacuation plan which informed staff about the safest way to evacuate people from the building in the event of an emergency such as a fire or flood.

Staff had completed first aid training and they were confident about responding to emergencies. There was first aid equipment available on each of the units, in the central laundry and in the main kitchen and staff knew where to find it.

There were sufficient numbers of skilled and experienced staff to meet the needs of people who used the service. The registered manager was based in a central office and each unit which was easily accessible to the office had a named manager and a team of care and ancillary staff. Trained nurses led on the nursing units and senior care staff led the residential units in the absence of the unit managers. The registered manager told us that they carried out an assessment to determine the number of different levels of staff required on each unit and that the outcome was based on people's dependency levels. We observed staff present at all times in communal areas which people occupied and staff regularly checked on people who occupied their bedrooms. Staff told us that there had been occasions when they would have benefited from more staff because some days had been busier than others and this meant people had to wait a little longer for assistance. However, staff did not report unsafe staffing levels and assured us that people had always received all the care and support they needed. Two people who used the service commented that they had waited on occasions for staff assistance but they commented that they understood It was because staff were busy with others and they confirmed that they never came to any harm. Family members raised no concerns about staffing levels.

Staff recruitment processes were thorough and safe to ensure staff were suitable to work at the service. We viewed recruitment records for eight staff members who held various roles including, trained nurses, care staff and ancillary staff. The records showed that applicants attended interview and underwent a series of checks prior

Good

Is the service safe?

to them commencing work at the service. For example, a minimum of two references, proof of identity and Disclosure and Barring Service (DBS) checks were obtained in respect of each applicant. Two newly recruited members of staff told us that they had completed an application form, attended interview and underwent a DBS check before they started work at the service.

People's medicines were safely managed. Medicines were stored in locked cabinets in dedicated rooms on each of the units. The rooms were clean, well-organised and kept locked by the key holder when not in use. Staff responsible for handling medication had undertaken appropriate training in the subject and we saw evidence that their competency was regularly assessed. Information and guidance for staff about medication procedures and codes of practice was displayed in medication rooms. Each person who required medication had an individualised medication administration record (MAR). We checked a sample of people's MARs and medication stock on each of the units. Medication tallied with the stock and records showed people had received their medicines at the right times, including time specific medication, for example before and after food. MARs also included important information about people, such as any known allergies and details of prescribed 'to be taken as required' medication. Records were kept of all medicines received into the service, those disposed of and others returned to the pharmacist. We observed staff administering medication to people. Staff were not disturbed whilst carrying out the task and were assured people had taken their medication before signing their MARs.

Good

Is the service effective?

Our findings

People told us they thought staff were well trained and good at their job, one person said, “The staff are well trained. They go on courses” and another person said, “They are marvellous and very good at what they do”. Most people commented that they liked the food however some people said it was not always good. People’s comments included; “The food is all right”. “They give me a choice of food”. “It’s sometimes cold” “We can have a hot meal twice a day if we want it”. “We get enough to drink” “The food is good. If you don't like it you can always get something”.

Staff received appropriate training and support which enabled them to meet people’s needs. All new staff completed an induction programme which included training in topics which the provider considered mandatory, such as; safeguarding, health and safety, fire safety awareness and moving and handling. Throughout their employment all staff continued to access refresher courses in mandatory topics and other more specialist topics. Specialist training was selected based on people’s needs and staff roles and responsibilities and included; dementia care, medication management, managing challenging behaviour and managing risk. Training was organised, delivered and monitored by an accredited training officer employed by the provider. Staff attended some classroom based training and completed other training via E-learning. Following each training session staff were required to undertake a knowledge test to assess their competency in relation to the training they had completed and we saw records which confirmed this. Discussions held with staff and records we saw showed staff had received training which was current and relevant to their work.

All staff received appropriate support and supervision and they told us they felt well supported in their role. The registered manager provided trained nurses with clinical support. All other staff had a named supervisor who provided them with regular one to one formal supervision sessions and an end of year performance and development review. All supervision sessions were recorded signed and dated by the staff member and their supervisor. Staff told us and the sessions provided them with an opportunity to reflect on their work and plan any future training and development needs. Staff shared examples with us about how they had been able to discuss with their supervisor, some personal issues which were impacting on their work and how they were supported. Staff told us that the registered manager was easily available for advice and support when required.

The registered manager and other staff had undertaken training about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager demonstrated that they had considered the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) for people to ensure their human rights were protected when their liberty was restricted in any way. The manager provided us with the details of people who had a DoLS authorisation in place and we saw appropriate care plans were in place for these. There was evidence of capacity assessments and consent to care documentation in people’s care records.

People’s dietary needs were understood and catered for and people received the support they needed to eat and drink. Where a person was at risk of malnutrition, appropriate care plans were in place. Care plans included advice and guidance obtained from dieticians and records showed this had been followed. For example, people’s weight, food and fluid intake had been closely monitored and any concerns which were noted were acted upon. We observed lunchtime in three of the units and saw that where people were either unable to eat in the dining room or chose not to, they were offered meals and refreshments in their bedrooms. Other people sat at dining tables and were served their meals and drinks individually. People were offered a choice of hot and cold meals and drinks and people at risk of weight loss were provided with high calorific food and drinks. Where people required assistance at meal times we saw staff sensitively and respectfully assisting people in an unhurried and calm manner. Main meals were prepared in the main kitchen and transported onto each of the units, however each unit had a small kitchen which was equipped with facilities which enabled staff to prepare snacks and drinks for people on request. The cook was knowledgeable about people’s dietary needs including those who required low or high calorific foods. We joined people for lunch and sampled a hot meal from the menu, which was also chosen and served to people who used the service. The meal was cold and we raised this with a member of staff who later brought a fresh plate of the same food and this was tepid. The food was dry, tasteless and unappetising to look at and the menu stated there was an accompaniment of sauce, which was not

Good

Is the service effective?

provided to anyone who chose that meal. Most people said they liked the food served at the service, however three people said they did not. We discussed people's comments about the food and our findings with regards to the meal at lunch time, with the registered manager and they assured us that they would address the issues.

People told us the staff would call a GP for them if they needed it. We saw health care professionals visit the home to provide services to people. Care records evidenced that a variety of support had been sought for people including, dieticians, speech and language therapists, and falls and continence advisors. Records also showed that people had been supported to attend or receive visits from primary health care services such as chiropodists, opticians and dentists.

Good

Is the service caring?

Our findings

People told us they received good care and support from staff that were respectful, kind, pleasant and caring. People comments included; “Staff are very nice”. “The staff are kind, caring and pleasant. They listen to what I say”, “The staff are constant and mainly the same ones every time”. “They make my family welcome”. “Staff are very well mannered, respectful and helpful”, “They respect my privacy and they know how to do their job properly”, “They know me very well” “You can have a joke with them and they are nice people”. Family members told us; “The staff behave wonderfully. They couldn't be nicer”, “The staff are very caring and hospitable”, “I've been 100% happy with their care and I want her [my relative] to stay here. I'll move heaven and earth to keep her here”.

People’s preferences with regards to how they wanted their care and support to be provided was recorded in their care plans and staff knew what people’s preferences were and they fully respected them. For example, staff knew which people preferred to be supported by staff of their own gender and one member of staff told us how important it was for one person to express their sexuality and the staff member detailed how they supported this.

There was a calm and relaxed atmosphere on the units and staff sat close to people and spent time chatting to them about things of interest. The conversations which took place indicated that staff knew people well and had a genuine interest in what people had to say. Staff shared banter with people and people appeared to really enjoy this. One person said, “We always have a good laugh, I enjoy a good laugh with the girls and they know that”.

Staff reassured and comforted people who were anxious and upset and they used diversion techniques to help calm people. For example, one member of staff comforted a person by holding their hand and walking around whilst talking to them about a family member. The person soon appeared less anxious. Another member of staff settled a person by offering them a cup of tea and a biscuit. The member of staff sat with the person and spent time chatting.

We saw that people who used the service had their own bedroom and that they had personalised them how they wanted, for example, with family photographs, ornaments and their own furniture. Some people chose to spend time in their room rather than in communal areas. Staff respected this and regularly checked on people to make sure they were comfortable and had access to a nurse call bell in case they needed to call for assistance. People who were being cared for in bed were clean and comfortable and staff spent time chatting with them.

Visitors were made to feel welcome and they could meet with people in private if they wished. Visitors told us they were always offered refreshments and had often been invited to join their relative for a meal. People who were receiving end of life care and their family members were treated with care and compassion. A family member of one person who was receiving end of life care said their relative had been treated with the upmost care and compassion.

We observed staff treating people with dignity and respect and being discreet when assisting people with personal care, for example bathroom and bedroom doors were kept closed and where possible people received personal care in their own rooms. Staff told us they had received training and had held regular discussions in supervision sessions and at staff meetings about the importance of ensuring people’s dignity. Staff commented that they treated people who used the service in a way that they would expect their loved ones to be treated. Staff knocked and waited for a response before entering a people’s bedrooms, toilets and bathrooms.

The registered manager was aware of how to contact local advocacy services and information about advocacy services was available on each of the units for people to refer to should they need this support. Brochures containing information about the service were given to people who used the service and they were made available should family members and other visitors wish to take one away.

Good

Is the service responsive?

Our findings

At our last inspection in August 2014 we were concerned because accurate and appropriate records were not maintained in respect of people's care. The provider sent us an action plan outlining how they would make improvements. At this visit we found the required improvements had been made.

Some people were unable to confirm if they had a care plan but they told us they received all the care and support they needed. People told us that staff listened to them and involved them in decisions about all aspects of their care and support. Family members told us they were aware that their relative had a care plan and that they had been invited to take part in care reviews.

People's comments about activities varied. Some people said there was plenty to do whilst others said they were often bored. People's comments included; "We play bingo and do exercises and all sorts of games. I enjoy them". "I get bored. There's nothing to do during the day". "There's sometimes singers come in. I do enjoy that. Apart from that we don't go out". "I'd really like to be taken out now and again in a mini bus to different places.

We looked at eight people's care files. People's needs had been assessed and a care plan developed for identified areas of need. Care plans accurately reflected people's care needs and there was evidence to show that people's care plans had been regularly reviewed and altered to reflect any changes. Review records detailed those involved including, where appropriate, family members and other professionals. This helped to ensure people received the right care and support.

Care plans included information about people's preferences, including their preferred and most effective way of communicating their wishes, choices, feelings and emotions. For example, one person's care plan stated that personal care was to be provided by two female carers. Another person's care plan stated that they were non-verbal and instructed staff to communicate with the person by use of gestures and to engage using direct eye contact. The care plan stated that the person used facial expressions to communicate things such as pain, hunger and thirst. This information enabled staff to recognise and respond to people's needs.

Two activity co-ordinators were employed at the service. Their role was to plan and facilitate activities for people on each of the units. People's interests and hobbies were recorded in their care plans and daily records detailed activities people had taken part in. The records showed that people had been provided with the opportunity to take part in things such as, sing a longs, painting, and reminiscence and craft sessions. However, there was little evidence to show that people had been offered with an opportunity to access the community. People commented that they had not been on any outings and would like an opportunity to do so. During our visit people were engaged in activities such as painting, dancing and hand massages. We discussed the lack of community based activities with the registered manager and she assured us that this was something which was being addressed as recent feedback from questionnaires sent out to people had highlighted this.

Staff had responded appropriately when they noted any concerns about a person's health or wellbeing by ensuring prompt referrals were made to other health and social care professionals. For example, we saw evidence of referrals made for people to dieticians, falls and continence services and the memory clinic. Following advice from other professionals, charts were put in place and completed as required for people who required aspects of their care monitoring such as weight, behaviour, positioning and food and fluid intake. Staff knew why the charts were in place and when they needed completing. They also knew what their responsibilities were for reporting any concerns highlighted in the records.

Daily records were completed for each person. They detailed all care given, contact with others such as family, friends and visiting professionals and where required mood, behaviour, food and fluid intake. These records enabled staff to have up to date accurate information to use to handover to the next shift and to evaluate and review people's care and support. We observed staff completing charts and daily records throughout the inspection.

Short term care plans were in place for people as required. For example; one person had a short term care plan for a wound which they recently developed and another person had one for an infection they had acquired. Care records for these people showed that staff had followed the plans as instructed and that people's health had improved.

Good

Is the service responsive?

Units which accommodated people living with dementia had some memorabilia such as pictures and ornaments to help stimulate people's memories. The units also had signs in place to aid the orientation of people, for example on doors such as the toilets and bathrooms and on walls close to the dining room. Memory boxes were mounted on walls outside bedrooms and some had old photographs of the occupant and of their family members. This assisted people to find their rooms more easily and it helped to generate discussions between staff and people about their past lives and family. Some memory boxes were empty and we discussed this with relevant staff who explained that they were waiting for family members to provide photographs and other memorabilia for their relatives.

People and their family members told us they knew how to make a complaint and were confident they would be listened to. A relative said, "I've no complaints but wouldn't hesitate to complain if I needed to." The registered manager told us she was always available for people to discuss issues and used complaints to learn from if required. We saw a record was kept about any complaints raised and there was documented evidence to support the investigation process which had been followed in line with the provider's policy.

The provider sent out questionnaires to people and their family members as a way of obtaining their views about the service. The questionnaires gave people the opportunity to rate and comment on things such as the care, staff, food and the environment. The results of questionnaires were analysed and used to make improvements the service people received.

Good

Is the service well-led?

Our findings

The service has had a registered manager since March 2015. People and their family members told us they knew who the manager was and that they liked her. Staff also said they liked the manager and they commented that she was approachable and supportive. Three staff members and two family members told us the service had improved a lot since the registered manager started work at the service.

Staff were familiar with the management structure of the service and their lines of accountability. Each of the units was separately managed by an appropriately qualified person and they were responsible for line managing staff on the units they worked. The registered manager visited each of the units on a daily basis and provided direct support to the unit managers, spoke with people who used the service, staff and visiting families. As well as providing general management support the registered manager also provided clinical support. However, the service was in the process of recruiting a clinical services manager who will be required to take the lead on clinical matters and provide direct support to trained nurses. In the absence of a clinical services manager the registered manager had received additional support from the provider. .

The registered provider had a system in place for reporting incidents and accidents and staff across the service were familiar with this. Records held on each of the units showed that staff had managed incidents and accidents in line with the provider's procedure. Each month a quality manager for the registered provider collected data about incidents and accidents which had occurred at the service. The quality manager worked alongside the registered manager to produce a report which identified any trends and ways of learning to prevent any future reoccurrences.

There were a variety of systems in place to assess the quality of the service, including audits and out of hour checks carried out by the registered manager and senior management team on behalf of the provider. Records showed audits had been regularly carried out on the environment, care plans, medication, staff training and performance, infection control and health and safety. Audit tools clearly identified what was needed to improve the quality of the service provided and who would be responsible for any actions. We saw that checks were undertaken to ensure actions had been completed within the timescales set. Unit managers and senior staff had also carried out regular daily, weekly and monthly audits which were checked by the registered manager. These included checks on medication stock and records, staffing, clinical risks, the environment and people's care.

A monthly maintenance audit was carried out across the service. The audit looked at things such as the general condition and safety of things including the décor, furnishings, fittings and equipment in the units, main kitchen, laundry and gardens. Records were up to date for checks which had been carried out on things such as fire alarms, firefighting equipment, gas and electricity systems and equipment such as lifting hoists, beds and the nurse call system and appropriate safety certificates were in place.

The registered manager and senior staff from each of the units attended a short meeting each morning to discuss the service. Topics discussed included; occupancy levels, staffing, care reviews and clinical and non-clinical risk on each of the units. This ensured that the registered manager had up to date information about the service which enabled them to manage it effectively.

The registered manager and registered provider had investigated complaints in a timely way and they had shared appropriate information when required with the relevant body such as local authorities and CQC. CQC were notified promptly of significant events which had occurred at the service. These ensured appropriate decisions could be made in relation to people's care and support.