Broadlands Nursing Home

Broadlands Nursing Home

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. This inspection was unannounced.

Broadlands Nursing Home is a care home for up to 25 people with nursing needs, many of whom were living with dementia. There were 20 people living at the home at the time of our inspection. 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 and has the legal responsibility for meeting the requirements of the law; as does the provider.

Before the inspection we reviewed the information we held about the service. At our last inspection in September 2013 we did not identify any concerns with the care provided to people who lived at the service. We spoke with the local safeguarding team and the local authority commissioning team to get more information about the service provided at the home.

Summary of findings

There were breaches of regulations in relation to care and welfare, assessing and monitoring the quality of the service, cleanliness and infection control, medicines management, meeting nutritional needs and consent to care and treatment, safeguarding people who used the service, respecting and involving people, complaints and supporting workers. You can see what action we told the provider to take at the back of the full version of the report.

We found gaps in the planning to meet people's individual needs and to ensure people's welfare and safety. Planning and delivery of care concerning people's moving and handling needs, wounds management, choking risk and nutritional monitoring was not always carried out safely.

Parts of the home and equipment were dirty and food hygiene procedures were potentially putting people at risk of food borne infections.

We found unsafe use and management of medicines. And people were not protected from the risks of inadequate nutrition and hydration. They were not provided with a choice of suitable food to meet their needs. People were not always given the necessary support, such as ensuring they had dentures that fitted their gums.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). No applications had been made to deprive people of their liberty and the provider had not considered whether any applications were required. Arrangements to act in accordance with people's consent were not always in place. Where people were thought not to have capacity to make certain decisions, mental capacity assessments were not carried out and there was little evidence that decisions were made in people's best interests in accordance with the Mental Capacity Act 2005 (MCA).

The manager and many staff we spoke with did not have a good understanding of the signs of abuse and how to respond appropriately to any allegations of abuse. Our findings were sufficiently serious for us to raise a safeguarding alert with the local authority.

People were not always involved in decisions about their care. For example, people were got out of bed early on different days according to a rota system to help the day staff. Staff did not always treat people with dignity and respect, such as by using people's rooms regularly to access the garden.

The complaints system had not been brought to the attention of people and their relatives in a suitable format.

Staff did not receive appropriate training, supervision and appraisal. We found that, in general, staff understanding of how to meet the needs of people with dementia was poor and we did not see evidence staff had been provided with training in this area. Staff had also not been provided training in MCA and DoLS.

The provider did not regularly assess and monitor the quality of services or identify, assess and manage risks relating to people's health, welfare and safety. We found serious risks of scalding and risks of falls from height through unsecured fire doors which the home had not identified. We reported to the Health and Safety Executive (HSE). We also identified concerns regarding fire safety which we reported to London Fire and Emergency Planning Authority (LFEPA). The service did not regularly seek the views of people using the service, relatives and staff.

The home had suitable arrangements in place regarding involving people in planning their end of life care. Also, people told us, and we saw, that staff treated people with kindness throughout our inspection.

Staff recruitment processes were safe and there were enough staff employed to meet the needs of people in the home.

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?

Inadequate

This service was not safe. Many areas of the home and equipment were dirty. We found faeces on a bathroom floor, for example. Food hygiene procedures put people at risk of food borne infections. Medicines were poorly managed with some people not being given their prescribed medicines when they needed them. We found a poor understanding of the signs of abuse and how to respond appropriately to any allegations of abuse.

Care was not always planned to meet people's individual needs and to ensure people's welfare and safety. Planning and delivery of care was not always carried out safely.

Arrangements to act in accordance with people's consent were not always in place and the home was not meeting their requirements in relation to Deprivation of Liberty Safeguards (DoLS).

Staff recruitment processes were safe and there were enough staff employed to meet the needs of people in the home.

Is the service effective?

Inadequate

The service was not effective. Staff did not receive enough appropriate training, supervision and appraisal. Staff understanding of how to meet the needs of people with dementia was poor. Records relating to the training staff had received were not maintained appropriately.

People were not always assessed appropriately to ensure that they were protected from malnutrition. People were not always involved in decisions about their nutritional needs and food was not always served at the correct temperature.

Is the service caring?

Inadequate

The service was not caring. While staff treated people with kindness, people were not always involved in decisions about their care. Also, staff did not always treat people with dignity and respect, for example regularly taking short cuts through people's bedrooms into the garden without considering people's wishes. A ground floor bathroom window did not offer adequate privacy to people bathing.

The home had appropriate arrangements in place regarding planning people's end of life care.

Is the service responsive?

Inadequate

The service was not responsive. People did not always have their individual needs regularly assessed and consistently met. People were not supported to pursue hobbies and interests. Several people may have been deprived of their liberty without the necessary legal authorisation.

The home had not brought the complaints system to the attention of people and their relatives in a suitable format.

Arrangements were in place to share people's needs when they moved between services.

Summary of findings

Is the service well-led?

The service was not well-led. The home did not regularly assess and monitor the quality of services or identify, assess and manage risks relating to people's health, welfare and safety. We found serious risks of scalding and fall from height which the home had not identified. We also identified concerns regarding fire safety and Legionella. The home did not regularly seek the views of people using the service, their representatives or staff. In addition, the home did not provide CQC with information requested before the inspection. The 'Gold Standard Framework' had accredited the home for their standards of end of life care until shortly before the inspection.

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Detailed findings

Background to this inspection

The inspection was carried out on 30 July and 7 August 2014 by an inspector, an expert by experience and two specialists (a registered general nurse and a commissioner with care home management experience). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spent time observing care and support being delivered. We also looked at records, including 13 people's care records, staff training records and records relating to the management of the service. We spoke with seven relatives, 11 members of care staff and the operations director. We also spoke with the registered manager briefly. We also spoke with 10 people who used the service. Some had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

The service was not safe. We found that people using the service were presented with significant risks to their safety which amounted to breaches of Regulations 9, 11, 12, 13 and 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of this report.

There was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care was not always planned and delivered in a way which ensured people's welfare and safety. People were not protected from avoidable harm due to inappropriate moving and handling techniques. We observed one occasion when staff were supporting a person to transfer from the stair lift to their wheelchair. The wheelchair started to move backwards during the transfer as the brakes had not been applied, and we had to intervene to stop the wheelchair from moving further until a member of staff applied the brakes.

We also saw, and staff confirmed, that none of the wheelchairs being used had footrests. We observed several occasions when staff had to tilt the wheelchair backwards to propel it forward in order to stop people's feet dragging on the floor. This method put handlers at risk of back injury. There was also a risk to people damaging their feet by them being dragged on the ground or being trapped under the wheelchair when it came to land after being tilted in the air. Staff told us that the lack of footrests was in response to an injury sustained by a person several years ago. We saw that a generic risk assessment was in place regarding this lack of footrests. However, it had not recently been updated and did not fully consider the risks to people using the wheelchairs and staff handling them.

For one person, the care planning documentation did not state the specific equipment that was required to help this person to transfer and how staff would support them. For another person their care plan identified that they required one staff to support them using a hoist to transfer. However, it did not specify how the transfer would be carried out safely with only one staff member. It also did not specify the type of hoist or specify the type and size of sling which was required. A third person's care plan stated they required two staff for all transfers, but also did not list specific equipment or slings required. These issues showed that the service did not have appropriate arrangements to address people's manual handling needs and put people at risk of unsafe care.

Records showed that three people had been assessed as being at 'very high risk' of developing pressure ulcers. However, the specific equipment to be used to reduce the risk was not identified in care planning documentation. Although we saw some pressure mattresses and cushions being used across the home we could not be sure that this equipment was appropriate to meet people's needs as people had not been individually assessed. This meant that the home did not have effective systems to plan care and treatment so as to ensure the welfare and safety of these people.

Where another person had chronic ulcers, records we were shown did not contain any information regarding the location, size and depth of the ulcer. There were no photographs or wound mapping. It was therefore not possible to monitor the wounds to find out whether they were healing or deteriorating so appropriate support could be sought. Staff confirmed that this person had not been referred to a Tissue Viability Nurse for specialist support. This showed that the home did not have an effective system to plan and deliver care and treatment so as to ensure this person's welfare and safety.

We saw behaviour charts in place for two people. For one person there had been over twenty incidents of aggression between March and July 2014, including that they had scratched, punched, hit and thrown objects at staff. However, it was not evident how this information was being used to inform care planning to help ensure their safety and that of the staff. Staff told us, and records showed, there had not been any referrals made for specialist support such as the local Older People's Challenging Behaviour Team.

We checked the bowel charts for nine people using the service during our inspection. For one person their chart showed they had not opened their bowels for almost 17 days. However, we saw their daily notes showed they had been "incontinent of faeces" almost five days before our inspection. Staff were unable to tell us whether this person had opened their bowels since this date. Similarly, records showed that two other people had last opened their bowels almost four days previously. One member of night staff told us they would check the charts each evening and

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Is the service safe?

leave a note for day staff in people's daily care notes when people had not opened their bowels for four days or above. However, there were no records to show, and staff were unable to tell us, the support which had been put in place for these people around their constipation and the associated risks to their health.

There was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that the manager did not always respond appropriately to allegations of abuse. The manager told us about a time when an incident of abuse had been brought to their attention, which resulted in a staff member being dismissed. However, the manager told us that they did not refer this to the safeguarding team because it was unnecessary as "this was something [the member of staff] said rather than did". This showed a lack of understanding that abuse can be verbal.

We spoke with seven staff about safeguarding and five did not show a good understanding of their responsibilities in relation to this. One member of staff was unable to describe signs and symptoms of abuse. When asked how they would respond if they saw bruising and suspected physical abuse one staff member was unable to tell us any action they would take to ensure the person was protected.

We were concerned that people were not safe in this home, due to the number of issues we identified. Because of this we raised a safeguarding alert to the local authority.

We did not find any evidence that people were supported to understand what keeping safe means or were encouraged to raise any concerns they may have had about this. Staff told us that these issues were not discussed with people in team meetings or otherwise, and that people were not supported to access advocacy services.

There was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found problems with the cleanliness and hygiene of the home. The home and equipment was not clean or hygienic. We checked two commodes and found they both had urine stains on the underside. A bath chair in a ground floor bathroom was stained and dirty. We rubbed a paper towel on the bathroom floor and saw that it was blackened. We checked two hoists in people's bedrooms and found them both to be dirty, again sampled using a paper towel. We found that the linoleum in an en-suite bathroom and in the corridor leading from the office to the lounge was ill fitting and lifting in places, which made it difficult to clean properly. A person's denture pot was encrusted with dirt and stained. In one en-suite bathroom there was faeces on the floor. We saw that the soap dishes and sink in one en-suite were very dirty, with lime scale build up around the taps. A shelf in this room was dusty. Several tiles were missing from the en-suite walls which meant the walls were difficult to clean effectively. We asked to see infection control audits and were told there were none. Although after the inspection the provider told us there was a cleaning schedule, we did not see evidence that this was used appropriately to maintain standards of cleanliness and infection control.

There was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff confirmed there were no medicines audits carried out which may have identified and resolved the issues we identified. Stock checks suggested that not all medicines which had been administered had been signed for appropriately, and some medicines had been signed for but not given. We were not always able to confirm medicines had been given as prescribed. One person had not received a controlled drug as prescribed, and so they had not received adequate pain relief.

Arrangements for managing controlled drugs were inappropriate. We saw that the controlled drug in stock was not recorded in the controlled drugs register. The home's policy stated that, "The doses given, and time of administration will then be entered into the Controlled Drugs Register against the service user's name, which is then signed by both nurses." There was no evidence that controlled drugs were administered with a second nurse acting as a witness.

We found that the arrangements for medicines storage were not appropriate. The home's medication policy did not cover procedures for medication storage. We found that a controlled drug was not always stored in the controlled drugs cabinet. We also saw that there were inadequate arrangements in place to ensure that medication was stored at the correct temperature at all times. During our inspection, when we notified staff that the temperature reached 25°C, they promptly put a fan in the medicines room in an attempt to lower the temperature. This was because medicines commonly require storage below 25°C to avoid damage or

deterioration. However, we checked the temperature of the room later in the day and found that the fan had not affected the temperature: the room temperature had reached 30°C. We saw that the home's medicines policy did not consider the temperatures for storing medicines and how the storage conditions should be monitored.

There were no clear procedures for giving medicines in accordance with the Mental Capacity Act 2005 in the medication policy or in people's care plans, nor for the administration of covert medicines or homely medicines. People may not have been given their medicines in a way which considered their capacity or complied with legislation and best practice.

Staff we spoke with told us there were usually enough staff to meet the needs of people in the home. However, staff said that there had not been enough staff recently due to colleagues taking annual leave. The rotas showed that several staff were working around 60 hours per week to cover unfilled shifts. Relatives we spoke with felt there were enough staff.

However, we noticed on staff rotas that from 7.30pm the numbers of staff reduced from four care workers and a nurse to two care workers and a nurse. Because of this we inspected the home in the evening to observe how the staffing levels impacted people. We observed that from the early evening several people in the lounge appeared tired with a number sleeping and staff started supporting people to go to bed individually. In the late evening there were still ten people in the lounge, with five people sleeping which suggested they would have preferred to have been in bed. Staff were only able to take people to bed gradually, as several people required the assistance of two staff. This meant many people were sleeping in the lounge for several hours before they were supported to go to bed. We checked people's care files and found that the time they would prefer to go bed was not recorded, and there was no evidence that people or their representatives had been consulted on this matter. These issues suggested that care had not been planned to meet people's individual needs.

There was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was no evidence in the ten care files we looked at, or in other documentation, that the service had obtained people's consent on individual aspects of their care such as their preferences for support with personal care, the rationale for restricting movement (the front door was locked) or taking medication. This showed that the service did not have arrangements in place to obtain, and act in accordance with, people's consent in relation to their care and treatment.

The service had not made suitable arrangements to implement or work with the Mental Capacity Act (MCA) 2005. None of the ten care files we looked at contained assessments of people's mental capacity and staff confirmed none had been carried out. There was no information to demonstrate that the service had taken any steps to work in people's best interests. This suggested that people may not be involved in decisions when they have capacity, and appropriate steps may not be taken when people do not.

We saw that one person had a "do not attempt resuscitation" (DNAR) form on their file which stated they had no capacity regarding this decision. There was no evidence of a mental capacity assessment having been carried out in relation to this and our discussion with this person told us that they may have had capacity regarding this decision.

We found that several people may have been deprived of their liberty without authorisation . We saw that one person had a 'restraint log' in their file which was undated but had been signed by the manager. It stated "[this person] is at risk of falls if [they] are not restrained during lunch and supper while staff are feeding other clients." The form stated that this person would be restrained for one hour at lunch and one hour at suppertime. We observed several people who were restrained with a wheelchair belt throughout the day. Also, we found bed rails were in place for several people across the home. People's files showed that risk assessments had been carried out. However, these assessments had not considered whether the bed rails constituted deprivations of liberty for individuals. Staff told us there had been no assessments as to whether applications for deprivation of liberty safeguards were required for these individuals, and no applications had been made.

The staff we spoke with did not have a clear understanding of their roles and responsibilities in complying with the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us and records showed they had not received training in these areas from the service.

Inadequate

Is the service safe?

We found that the home operated safe recruitment practices. Staff who had started work recently told us they had had an interview and before they started work, that the provider obtained references and carried out a criminal records check on them. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Each person had references from previous employers, as well as a criminal records check in place.

Inadequate

Is the service effective?

Our findings

The service was not effective. We found breaches of Regulations 12,14, and 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of this report. In addition, the provider was breaching the regulations relating to infection control and supporting workers.

There was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked to sample some food about to be served and found that it was not warm. We saw that there was no mechanism for keeping food warm as it was brought from the kitchen to the dining area. We asked staff to provide us with a food temperature probe to test the temperature and were told by the person cooking that they had not used one as there was not one available, although later in the day it transpired that there was a probe available. As the person cooking was not aware of the probe, this showed that it was not used to check the food had been heated to an appropriate temperature before it was served. We asked to see records of temperature checks done before food was served. However, staff told us that this had not been recorded since 27 July 2014 as the template could only be printed out by the manager and they were absent from work. There was also no evidence that the temperature of the fridge and freezers had been monitored since the same date. People had been put at risk of food borne infections through ineffective systems to reduce food contamination.

There was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not always provided with support, where necessary, to enable them to eat and drink sufficient amounts for their needs. The person who told us their dentures did not fit them said, "I would like dentures but they fall off." We checked this person's care records, as well as those for four other people, and they did not show any evidence of dental appointments. Staff were unable to confirm they had received recent dental care. This suggested that the home was not responsive to the likelihood of people's gums shrinking, and did not ensure regular refitting of their dentures to help them with eating.

During our observations we used a tool called the Short Observational Framework for Inspection (SOFI) to gather information about the experience of care from the point of view of people using the service. We saw that support was provided to some people individually. At lunch we saw that some specialist equipment was used, such as adapted cups and plate guards. We saw that one person had special cutlery which they told us they found useful.

However, staff did not routinely check whether other people were experiencing any problems, such as whether they were enjoying the food or whether they were eating. We observed that one person had stopped eating their food. Staff did not notice this until we told them ten minutes later.

People were not always provided with a choice of suitable and nutritious food. We saw that only one meal was cooked at lunchtime, and people were not offered a choice. Staff told us that people could have an alternative meal if they requested it, however, many people were not able to, or may have felt uncomfortable, requesting something different. When we asked one person how their meal was they replied, "You can chuck it away!". They told us they did not like the food, and had never liked this particular meal. Staff brought an alternative of mashed potato instead of lasagne after we notified them. Another person told us they were unable to eat their food as it was too hard and their dentures did not fit them. We saw that the food they were provided with was not appropriate for their needs. Another person told us, "The food is not as good as it could be. I thought it might have been beef or chicken [I had for lunch]. I couldn't cut it, it was so hard."

Two relatives and one person using the service gave us examples of how they regularly provided some of their own food and condiments when these were not provided as standard. This showed that the home had not made efforts to cater to people's individual food preferences.

Meals were not appropriately spaced or flexible to meet people's needs. Staff told us, and we saw, that the evening meal was served at around 5.15pm and breakfast the following morning at 8.15am. This meant that there was 15 hours between these two meals. Staff told us that snacks were provided between mealtimes by request. However, we saw that many people would not have been able to make such a request. One person told us, "Supper is at 5pm which is early. I am used to eating my evening meal at 7pm."

There was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff did

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Is the service effective?

not have effective support, supervision and appraisals. We looked at the supervision and appraisals for three staff. We saw that two staff had not had an appraisal for over two years and the other for over a year. One staff member had a recent supervision recorded. However, records showed that no issues were raised or goals set except to "continue working as a team with other staff". This suggested that this supervision was not used effectively to support the staff member in relation to their responsibilities. Another staff member had no records of any supervisions on file, and the third person had no supervision recorded for over four years. A different member of staff told us they received supervision once a year; another told us they had had one supervision this year, and another, none.

People were not always supported by staff who had the necessary skills and knowledge to meet their assessed needs, preferences and choices. We observed that staff did not always respond appropriately to people living with dementia who were distressed and looking for family members. Our discussions with staff showed that they were not trained or supported to recognise and manage behaviours which challenged the service as distress reactions and to identify the cause of the distress and deal with it. Staff had also not received training in Mental Capacity Act (2005) and DoLS.

Recording systems in the home meant it was difficult to ascertain what training staff had received. We requested but were not provided with training records to show evidence that any staff had received training in dementia and safeguarding people from abuse. However, five staff we spoke with told us they had done safeguarding through the local authority in 2013. Other staff told us they had done dementia training via distance learning recently. The service could not provide evidence that staff had done the training they said they had done.

Staff told us, and records showed, that a GP visited the home regularly. Records also showed that some people had received recent visits from social workers and an optician.

Inadequate

Is the service caring?

Our findings

The service was not caring and the provider was breaching Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to respecting and involving people. The action we have asked the provider to take can be found at the back of this report.

We spoke with five people who told us that staff treated them with kindness and compassion. One person said, "The [staff] are marvellous how they help day and night, they really are." Another told us, "They're wonderful lovely girls. No matter what you want you get". However, one person told us, "Most staff are pleasant, you can have a bit of a laugh with them. But there are one or two you can't talk to." All the relatives with spoke with told us the staff were caring.

However, we found that people were not always involved in planning and making decisions about their care and support. Three staff and one person using the service told us about a system in place to get people out of bed early in the morning according to a rota. One staff member told us, "We get people up in groups to help with the morning staff." And two other staff members confirmed that this system was in daily use. One person told us, "They have these grades, I come under group ['X'] which means I have to get up early Wednesday and Saturday at 6am because there are others they've got to look after." People's care plans did not reflect what time they generally preferred to get up in the mornings. These issues showed that the system in place was to fit in with the staff available, and not with people's preferences.

There were not suitable arrangements in place to ensure people's dignity and privacy. We saw that a ground floor bathroom had transparent windows with a net curtain. This meant that, particularly when it was dark outside, people might see in while they were receiving care.

Through the day we observed staff using people's bedrooms as a passage to the garden, even though there were alternative paths, sometimes while people were using their rooms, with a lack of consideration for their wishes.

We found that where people talked about their lives and preferences readily, staff had come to know about their life histories. However, where people were more reserved, or not able to express themselves, staff did not know their preferences or life histories. For example, at lunchtime we saw staff were not aware that a person did not like lasagne.

We observed lunch in the home and saw that most staff interaction with people was positive. Most staff encouraged people and offered food at a suitable pace, waiting for them to finish the previous mouthful. However, we saw one staff member continually offering too much food to a person they were supporting to eat. Staff did not always stay with people who they were supporting to eat and so people had to wait for them to return to continue their meal. After lunch we saw one staff member wheel a person away from the table without saying anything to them or asking if they wanted to be moved. This showed a lack of consideration to this person.

Information about people was treated in a confidential way. All personal information was kept in lockable offices to make sure it remained confidential. We saw that when staff wished to discuss a confidential matter they did not do so in front of other people who lived at the home. We observed bedroom and bathroom doors were kept closed when care was being provided. However, staff did not always treat people with consideration and respect. We read people's daily care notes, and while most comments were respectful we found example of language such as "demanding at times" and "moody early morning".

We saw that, in the lounge, chairs were not arranged in groups to encourage socialisation, but were instead placed around the borders of the room.

Staff told us that people were able to choose the colour of their bedrooms. However, besides this we saw no other examples of people being involved in decisions relating to how the home was run. For example, we found no evidence that people were involved in creating the menu.

Suitable arrangements in relation to end of life care were in place. We saw 'Thinking ahead – advanced care planning' records in people's files and that people's preferences and choices for their end of life care were clearly recorded. We saw evidence of discussions with people and their relatives about how their would like their end of life care to be delivered. Responses to questions such as "What elements of care are important to you and what would you like to happen in the future?" and "Is there anything you worry about or dread happening?" had been recorded. One

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Is the service caring?

visitor told us how their relative had passed away in recent times in the home, and they were provided with excellent end of life care, and they wanted to continue visiting other people in the home.

Relatives told us they were able to visit without undue restriction. One relative said, "I can visit any time, no appointment necessary."

Medicines prescribed 'as required' or 'PRN' may have been administered inappropriately. Staff told us there was no written guidance for individuals as to when these 'as required' medicines should be administered, and the actions they should take to avoid this action beforehand. For example, where one person displayed behaviour which challenged the service, there were no guidelines as to how staff should recognise that they were anxious and then work with them to reduce their anxiety instead of immediately administering an 'as required' medicine. We saw that this staff had administered an 'as required' medicine to this person daily to reduce their anxiety. There was no recording system in place to log why 'as required' medicines such as this were administered. This meant that the service could not then analyse whether the techniques being used to support this person to avoid using this medicine were appropriate. This person was not protected from the risks associated with the unsafe use of this medicine.

Inadequate

Is the service responsive?

Our findings

The service was not responsive. There was a breach of Regulation 9 and 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of this report.

People did not always have their individual needs regularly assessed and consistently met. We did not see any choking risk assessments in any of the ten people's documentation we looked at or guidelines for staff to follow to reduce choking risk. Staff we spoke with were not aware of any such risk assessments, guidance or of any referrals to a specialist having being made for any people in the home in relation to choking.

Staff told us, and records showed, that one person had recently been referred to a dietician when staff identified issues relating to their nutrition and hydration. However, we found that people's nutritional needs were not always monitored and managed. We saw that several people had 'Malnutrition Universal Screening Tool (MUST)' assessment. The organisation which produced this tool advise that reviews are carried out monthly for it to effectively monitor people's nutritional status. However, we saw that for six people there had been a failure to monitor their nutritional status monthly to protect them against the risks of unsafe care. For one of these people records showed that they had not been able to be weighed since April 2014 and their care plan and risk assessments had not been reviewed in light of this. There were no records of, and staff confirmed that, there had not been any attempts to monitor the person's nutritional status through other means.

One person was in bed throughout both days of our inspection who was unable to communicate with us verbally. Their care planning documentation did not clarify why they stayed in bed for so long. Although there was a generic care plan regarding social isolation for this person, this was not individualised enough to show what was in place to prevent the risk of social isolation for that person. Staff told us the person remained in bed because they were "frail", and they were supported to sit in the lounge three times a week. However, we could not find reference to this in their care plan. Because of this, this person was being put at risk of social isolation through ineffective care planning.

The provider did not have adequate arrangements in place to meet people's social and recreational needs. We did not see any evidence that people had individual planned programmes of activities or were supported to pursue hobbies and interests. People's hobbies and interests were not always recorded in their care plans. We saw that where hobbies and interests were recorded, there was little evidence to show how this identified how people should spend their days. For example, for one person it had been identified that they enjoyed talking books, but we found no evidence that these had been provided. Another person told us they would like to try knitting with adapted needles and confirmed staff had not supported them to do this. One staff member told us, "No one here has their own hobbies."

There was an activities officer working at the home three days a week, but we saw that there was a reliance on this person to organise and run activities. One relative told us, "There is lots going on here, nails, colouring, and games. Once a month an entertainer comes with an accordion to sing. [My relative] loves it and sings along." However, we saw that there was little to do in the lounge when the activities person was not present, such as on the second day of our inspection. We asked one person what they did during their days and they told us, "Nothing really. I just sit here and watch TV." We observed sing-along but people seemed to be disengaged. Staff showed us drawers of games and activities in the lounge, but we did not see staff, besides the activities officer, using these. We found that there was no evidence of, and staff were unable to show us, a planned programme of activities, and staff could not tell us how people were involved in planning activities. A newsletter had been produced. This showed that games such as a guessing game, looking at old photos, floor basketball and arts and crafts had been provided.

Our discussions with staff showed there was little community involvement, with people seldom being supported to do activities outside the home. We were told that recently two people had been supported to visit Brighton, and that quite a few people went to a local park on one occasion last summer. However, staff told us that the home has close links with a local church and a vicar visits every few weeks.

There was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People's concerns and complaints were not encouraged and people

Inadequate

Is the service responsive?

who lived in the home were not provided with information about the home's complaints procedure. The manager told us no complaints had been received and the complaints book showed none recorded at all from April 2003 to the date of the inspection. There was a complaints policy in an office file, but this was not on display in the home or provided to people in an accessible format, although saw a version of a CQC complaints procedure on display in a communal area. People using the service and their relatives told us they were not aware of, and had not received a copy of, the complaints policy when they joined the service. Relatives we spoke with told us they had not had cause to complain, and when they had raised concerns with the manager in the past the manager had responded well. However, because the service had not brought the complaints system to the attention of people using the service and people acting on their behalf in a suitable manner and format.

People's needs were recognised and shared when they moved between services. Staff and a relative told us that when a person was admitted to hospital staff provided a referral letter explaining why they required hospital support, a copy of their MAR chart, a contact list of people who are significant in their life and information about their diagnoses. A relative told us that when their family member was admitted to hospital in an emergency recently staff had contacted them immediately to inform them. Their daily records showed that the home had been in daily contact with the hospital throughout the person's stay, and notes were made as to how they were progressing.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. We found that people using the service were presented with significant risks. There was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of this report.

The service did not always identify, assess and manage risks relating to the health, welfare and safety of people or others who may be at risk from the carrying on of the regulated activity. We asked a nurse to provide equipment to enable us to test the temperature of the hot water. The equipment provided was inappropriate as it was made of glass, was not able to be easily cleaned and, being a room thermometer, was unable to accurately measure the high water temperature in some of the outlets we tested. The nurse told us there was no other equipment available to measure the water temperatures.

We tested the hot water temperature from the outlet of a communal ground floor bath and found this to measure 49 degrees Celsius on the equipment provided. This is above the temperature recommended by the Health and Safety Executive "Managing the risks from hot water and surfaces in health and social care". If hot water used for showering or bathing is above 44 °C there is increased risk of serious injury or fatality. Where large areas of the body are exposed to high temperatures, scalds can be very serious and have led to fatalities.

We also tested the temperature of the hot water outlets of a communal and an en-suite bathroom on the first floor. However, the maximum temperature able to be measured by the equipment we were provided was 50 degrees Celsius. The readings from both outlets reached this maximum. This meant that that temperature of water from these outlets also put people at risk of scalding.

Staff told us there were no, and we saw no evidence of, risk assessments in place regarding the scalding and burning risks in the context of the vulnerability of those being cared for. Risk assessments were not in place to identify what controls were necessary and how the systems would be managed and maintained.

Staff told us, and there were no records to evidence, that the temperature of hot water outlets was tested to ensure that the temperatures were controlled and did not put people at risk of scalding.

We saw a pile of disused furniture at one side of the garden with a plank of wood which had nails sticking out. We did not see any evidence that the risk of people injuring themselves on these nails had been identified or risk assessed.

We saw a fire door in a shared bedroom on the first floor. We pushed the bar on the door and noticed it opened immediately, without restriction. There was a similar door leading to the same roof area in another person's bedroom. The operations director confirmed it was not monitored by any alarm system to notify staff in the event of it being opened. We saw that the door led onto a section of the roof with drops either side, and a fire escape at the end of a short path. People were at risk of falling from height because of this. Staff confirmed, and there was no evidence to show, risk assessments were place relating to this risk. However, during the second day of our inspection we saw that this fire door had been upgraded so that it was linked to the fire system and only opened in case of a fire, or a call point being broken. These issues showed that the system in place to identify, assess and manage risks relating to health and safety was ineffective as it had not identified this issue, and the provider only acted when this was pointed out by CQC.

We saw that a fire risk assessment had been carried out in October 2013 by an external company. However, we saw that several actions which had been identified to keep people safe had not been carried out. These included carrying out a wiring check, improving signage around the home, installing a smoke detector in storeroom linked to the fire alarm and improving seals around fire doors. In addition, there was no evidence of personal emergency evacuation plans (PEEPs) for all people to assess and plan how they would escape in the event of a fire, and to ensure that appropriate fire safety measures were in place. We informed the London Fire and Emergency Planning Authority (LFEPA) about these concerns.

There was no evidence of personal emergency evacuation plans for individual people to ensure that means of escape

Inadequate

Is the service well-led?

in case of fire and associated fire safety measures were provided for all people who may be in a building were both adequate and reasonable, taking into account the circumstances of each particular individual.

We saw that an external company had carried out a Legionella risk assessment in January 2014. However, many tasks deemed to be high priority had not been actioned at the time of our inspection. Legionella is a bacteria which can accumulate rapidly in hot water systems if control mechanisms were not in place. The poor management of these risks meant that people were at risk of acquiring Legionella infections, which can be fatal. We reported this concern to HSE.

We did not see mechanisms in place to regularly seek the views (including the descriptions of their experiences of care and treatment) of people using the service, persons acting on their behalf and persons who were employed at the home to enable the registered person to come to an informed view in relation to the standards of care and treatment provided. The manager informed us on 30 June 2014 that there were no meetings for people using the service, and we did not find any records of these. We did not find evidence of people's views being obtained in any other ways. The policy "Monitoring resident's feedback regarding the care service" stated that "as far as work load permits it is the home's objective to obtain feedback from at least one person per week. This will be done on a rotating basis ensuring all people's views are obtained." However, we did not see evidence that this was taking place.

Records showed that a 'relative's audit' to gather feedback from relatives had last been carried out in 2011. Friends of Broadlands meetings took place but the minutes showed that the purpose was to discuss fundraising, not to gather views.

Records of minutes showed staff meetings took place on 16 June 2014 and previously on 30 August 2013 and then 6 March 2013. The records did not reflect that these meetings were used to seek the views of staff and their contribution in providing a service to people.

Records showed that audits were carried out by the senior management, however, these did not show evidence that people's views were sought as part of this process.

We looked at systems in place to monitor the quality of the services provided by the home. We noted that there were no systems in place to monitor the standard of medicines management, infection control and cleanliness.

The "Staff meetings and management reviews" policy stated that "Quality Management Review meetings will be convened on a 6-monthly basis…." to discuss, "results of the latest self-assessment (internal quality audit) performed, with preventative/ corrective action requirements, as appropriate…up-date of staff training needs through the continuing validity of staff training plans…review of any resident, relatives and visitor questionnaires completed since the last review meeting with the view to possible preventative/ action requirements." However, we did not see any evidence of these management review meetings taking place. We also did not see evidence of a staff training plan. Without a system to monitor the quality of the care provided to people using the service or to assess risks of unsafe practice, people were placed at risk of receiving support that does not meet their needs or keep them safe from potential harm.

We found that there was not an emphasis on ensuring accurate handovers between shifts. The rotas showed there was no time scheduled for handovers between most shifts. We observed a handover and saw that staff leaving the shift were expected to carry out this exchange of information in their own time, unpaid. Although staff handed over appropriate information about each person, we saw that there was an emphasis on finishing as soon as possible because effectively staff had already finished work. These issues meant that important information may not be handed over appropriately in all handovers which may adversely affect their health, safety and welfare.

There was a system in place to report accidents and incidents. We saw that accidents were recorded into a log book. However, records showed that people's care plans and risk assessments were not always reviewed and updated in light of accidents and incidents involving them.

Records showed that the fire alarm as well as automatic door releases and means of escape were checked weekly although the emergency lighting was last checked in October 2013. However, records showed that checks of the fire system and fire fighting equipment had taken place

Inadequate

Is the service well-led?

regularly. Records also showed that testing of portable electrical appliances (PAT testing) had been carried out within the past year, as well as a gas safety and boiler check.

We found some monthly health and safety checks in place including checks of the bath hoist, mobile hoists, bed rails, water tank, sluice, pressure mattress, wheelchairs and call bell. However, none of these checks had been completed since May 2014. Also, we did not find any master list of all the slings in the home showing their name, size and serial number to ensure they were regularly checked.

Before this inspection we asked the provider to submit a 'provider information return' report to tell us how they assess and monitor the quality of service provided and the risks they have identified and how these were managed in the carrying on of the regulated activities. The provider failed to submit this.

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 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who used the service were not safeguarded against the risks of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and by responding appropriately to any allegation of abuse. Regulation 11(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services There were not suitable arrangements in place to ensure the dignity and privacy of people, or to ensure that people were enabled to make, or participate in, decisions relating to their care or treatment. People were not always treated with consideration and respect or provided opportunities for community involvement. Regulation 17(1)(a)(b)(2)(a)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person had not brought the complaints system to the attention of people using the service and persons acting on their behalf in a suitable manner and format. Regulation 19(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

The registered people did not ensure that people employed by the home were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people using the service safely and to an appropriate standard by receiving appropriate training, supervision and appraisal. Regulation 23(1)(a)

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 and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used services were not protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs and ensure their welfare and safety. Regulation 9(1)(a)(b)(i)(ii)iii)(iv)(2)

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who used the service were not protected against the risks associated with an ineffective operation of systems to regularly assess and monitor the quality of the services and to identify, assess and manage risks relating to the health, welfare and safety of people and others who may be at risk from the carrying on of the home. The registered person did not regularly seek the views of people using the service, persons acting on their behalf and staff. The registered person did not, when requested to do so, send the Commission, a written report setting out how the requirements were being met and any plans to improve the standard of services. Regulation 10 (1)(a)(b)(e)

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People using the service, staff and others were not protected against identifiable risks of acquiring an infection by the means of an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a heath care associated infection, or the maintenance of appropriate standards of cleanliness and hygiene in relation to premises or equipment used for the purpose of carrying on the regulated activity. Regulation 12(1)(a)(b)(c)(2)(c)(i)(ii)

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services and others were not protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the recording, safe keeping and safe administration of medicines. Regulation 13

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not protected from the risk of inadequate nutrition and hydration by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet people's needs; and support for the purposes of enabling people to eat and drink sufficient amounts for their needs. Regulation 14(1)(a)(b)(c)

The enforcement action we took:
A warning notice was issued.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people using the service, or establishing, and acting in accordance with, the best interests of people using the service. Regulation 18(1)(a)(b)(2)

The enforcement action we took:
A warning notice was issued.