Mr & Mrs K Kowlessur

Broad Acres

Inspection report

Leiston Road
Knodishall
Saxmundham
Suffolk
IP17 1UQ

Tel: 01728830562

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2 February 2016 and was unannounced. Our inspection of January 2015 found that improvements were required in the management of the service. At this inspection we found that there were some improvements but there was still further progress to be made in this area.

Broad Acres provides care and accommodation, including nursing care for up to 48 older people, some of whom may be living with dementia. On the day of our inspection there were 40 people living in the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff had a good understanding of what constituted abuse and told us that they would be confident to recognise and report it. Senior staff, including the registered manager, were aware of their roles in relation to reporting allegations to appropriate external agencies. Staff were recruited safely and appropriate background checks carried out.

The registered manager did not have a formal 'tool' to assess staffing requirements. People and some staff told us that staffing levels could be stretched particularly at busy times such as in the evening when people wanted support to go to bed.

Risks to people such as falling or acquiring a pressure ulcer were assessed and actions to mitigate the risk put in place. These risk assessments were reviewed regularly and amended where necessary.

People's fluid intake was not always recorded and monitored effectively. Drinks were not left within easy reach of people to encourage fluid intake. The dining experience was calm and relaxed with staff promoting independence and encouraging people to eat sufficient amounts.

People were supported to access healthcare professionals such as a chiropodist and GP.

People and their relatives, where appropriate, were involved in their care planning. People's privacy and dignity was now always respected with night staff leaving all bedroom doors open.

The decoration and signage within the premises did not meet the needs of people living in the service, particularly those living with dementia.

The service had made appropriate referrals under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, recommendations by the authorising body had not always been followed. Staff had received training in the MCA but this was not always put into practice.

Care was not always provided in accordance with people's assessed needs, particularly in regard to those living with dementia. Staff did not always communicate with people in a way which they could fully comprehend.

Resident, relative and staff meetings were not held regularly to ensure that people could express their views and be involved in the development of the service. The manager called a meeting when there was something to discuss.

The service did not implement up to date policies and procedures. Quality assurance audits and internal quality audits were not used to drive improvement in the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service was safe.

People had mixed views as to whether there were sufficient staff. The provider was unable to demonstrate how they ensured there were sufficient staff to meet people's needs.

People were protected from abuse and avoidable harm by staff who understood the risks and knew how to report and deal with concerns.

Medicines were managed safely and people received their medicine as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Where people required their fluid intake to be monitored this was not carried out effectively.

Staff did not always follow the principles of the Mental Capacity Act 2005 when providing care. Recommendations made by other professionals had not been fully explored.

People were supported to access healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and independence was not supported by the service décor.

Staff treated people with dignity respect and kindness.

People were able to express their views regarding their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was in accordance with their care plan

Opportunities to explore ways of supporting people with complex needs were not always taken.

The service had a complaints procedure which was displayed in the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service did not keep up to date with current best practice guidance.

Information from surveys was not used to drive improvement.

Audits were not effective in ensuring the quality of the service.

Broad Acres

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 February 2016 and was unannounced. It was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of dementia care.

Before the inspection we reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

During our inspection, we spoke with 15 people who lived at the service, two relatives, six members of the care staff and the registered manager who is also the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at seven people's care plan records and other records related to the running of and the quality of the service. Records included staff files, audit reports and questionnaires which had been sent to people who used the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. One person said, "Yes I do feel safe and most of the staff are alright." Another person said, "Girls are alright, I could talk to staff if I had concerns." A relative told us they felt able to talk to the manager or a member of care staff they knew well if they had any concerns.

Staff told us, and records confirmed that they had received training and regular updates in ensuring that people were safe. Staff had a good understanding of protecting people from harm. They were able to tell us about different types of abuse, such as physical or emotional abuse, how to recognise potential harm and how to report it. They said that they would be confident about reporting suspected harm or poor care practices within the service and knew how to report concerns to external organisations such as the local safeguarding authority if necessary. This showed us that that there were systems in place to help ensure that people were as safe as practicable.

Risks to people, including those at an increased risk such as eating, drinking, moving and handling and health conditions were managed effectively. This included the provision and use of mobility equipment, appropriate diets to reduce people's risk of choking and sensors in place to alert staff if people got out of bed. People's level of risk was documented in care plans and updated in response to changes. Effective measures such as regular repositioning of people were in place to support people with risks such as with their skin integrity. This meant that people were looked after safely according to their assessed needs at the time. A relative said, "I told the manger when [relative] arrived that she was inclined to fall at night so they put down a crash mat and an alarm to protect [relative]."This meant that there were processes and measures in place to support people safely and manage risks.

People had mixed views as to whether there were sufficient staff available to meet their needs. One person said, "Buzzer – takes a little while but not too bad, it's the same day and night." However, another said, "I don't think they have enough staff, at 6 o'clock when I want to go to bed they are pushed," with another saying, "There is not enough staff in the evening time, that is the busiest time."

Staff we spoke with mostly felt there were sufficient staff to enable them to meet people's needs. However, they did say that at times of higher demand, such as when people wanted to go to bed, they could be stretched.

The manager told us that they did not use a dependency tool to assess the numbers of staff needed in line with people's needs. They said that they used the numbers guidance from a previous regulator. The registered manager said that they were able to manage staffing levels as they monitored this by working in the service. They gave us an example of when they would increase staff numbers, such as when a person needed to be supported with a visit to hospital. Without robust assessments the service cannot be assured that there were sufficient staff numbers on duty at all times to meet people's needs.

We looked at a sample of staff files to check that the appropriate checks had been carried out before they were employed. Personnel files demonstrated safe recruitment and management of staff, especially in

checking references and criminal record checks so that the provider could be assured staff were suitable to work with people living at the service.

We observed staff providing people with their medicines. This was done in a supportive manner; staff explained what they were doing and offered people a drink to help them swallow any medicines.

We looked at a sample of medicine records, the storage of medicines and checks on the management of medications. Medicines were stored safely and managed appropriately to ensure that people living at the service received their medications in a safe and effective manner. We observed staff safely storing medicines in a locked office and noted the room was kept clean and tidy and free from hazards.

Requires Improvement

Is the service effective?

Our findings

Care records contained an assessment of people's fluid and nutrition requirements which explained what they needed and how they needed to be supported. However we observed that there were opportunities missed to ensure that these needs were met in practice. For example care plans for two people stated that they should be encouraged to drink, but we observed that they did not have easy access to fluids in between the two hourly hot drinks given by staff. The registered manager told us that some people were not left with a drink because they may require assistance and that there was a jug of water available for them to help themselves. Some people were not able to make the decision to help themselves to a drink and were physically unable to help themselves, but we saw they were able to consume their hot drink independently without support from staff. We were therefore concerned that the practice at the service did not always enable people to take a drink independently.

Where people had been assessed as needing their fluid intake monitored this was not carried out robustly because records were not accurate. Fluid charts did not always show the total intake for the day and there was a lack of oversight in place to identify this and prompt action to put it right. Charts did not record cold drink intake during the day, which also added to our concern about people's access to fluid between the hot drinks served by staff. For one person they were not recorded as having any fluid after 5pm for four consecutive days. This meant that either fluid was either not being offered or not taken, putting the person at increased risk in relation to their health and well-being, or that fluid intake was not being recorded. We found that staff were not making accurate and timely records of fluid intake.

This was a breach of Regulation 17(2) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's individual needs were not met by the decoration of the service. The signage and decoration of the service did not help to meet people's needs and promote their independence particularly those living with dementia. The colour of corridors and communal rooms was not designed to support people living with dementia by clearly identifying different areas through the use of distinctive colours and easily seen signage. For example the doors to toilets had differing signage none of which was dementia friendly. Carpets in some communal areas had recently been replaced but the design of these carpets was not in accordance with current best practice in dementia care. This did not conform to the provider's statement of purpose which stated that, 'Providing an environment that encourages and maximises client's independence within their own sphere and capabilities, irrespective of the time taken to perform tasks and may involve some degree of risk taking.'

This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the two communal dining rooms and found the dining experience to be calm and relaxed with staff promoting independence. People told us they enjoyed the food with one person saying, "I had pate, chicken, fruit cocktail for lunch, porridge and tea for breakfast and if I hesitate when they ask me for my food

choices they offer me something else."

Staff we spoke with told us the training was good. Staff told us that the registered manager encouraged them to undertake national qualifications in care. They received training in relevant subjects such as manual handling, first aid and dementia care. The manager maintained a record which identified what training staff had undertaken which allowed them to monitor training and ensure staff were up to date.

We found that in some areas the training staff had was not consistently put into practice. For example although they had received training in dementia care staff did not always communicate with people in a manner which enabled them to fully understand what was being said. For example, when one person was calling out a carer told them they would be back in five minutes. People living with dementia may lose the concept of time passing and this would have meant nothing to the person.

Staff told us they received regular supervision sessions which were supportive and where they could discuss any areas of concern they may have and any development needs. New staff received a planned induction into the service which included a period of shadowing an experienced member of care staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty. Broad Acres had four such applications authorised. However, we noted that one authorising authority had recommended 'Creative age appropriate use of farming sounds, pictures, videos and trips to see fields being ploughed and harvested.' We noted that the service had not fully explored these suggestions.

Staff had received training in the MCA however they did not always put this into practice. For example we observed that one person had requested to eat their lunch in the lounge and this was brought to them. However, when the member of staff had brought the meal they attempted to put a clothes protector on the person without asking. The person responded by saying, "What on earth do I want that on for."

People were supported to maintain good health, have access to healthcare services and receive on-going health care support. A relative told us, "The specialist comes and sees [relative], the GP and she had a flu jab." Another person said, "Dietician, chiropodist and doctor comes." Records we saw confirmed that people had access to healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

Whilst people were positive about the care they were provided with there was room for improvement within some practice at the service.

The provider had not fully considered how to ensure that the running and management of the service was conducted in a way that ensured people's privacy and dignity at all times. The décor of the service alongside notices for staff and storage of personal items did not always respect people's dignity. For example, there was a generic approach to protecting seats from incontinence by placing seat pads on all armchairs. This assumed that everybody would need one and suggested that continence was not being managed effectively. Reminders and notices for staff about how to provide personal care were on public display.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'

We observed kind and compassionate interactions between people and staff. One person said, "Staff are very good, friendly and will do anything to help."

Throughout our inspection we saw that staff treated people respectfully. When staff provided support to people they talked them through the process ensuring they were secure and comfortable at all times. When people required care and support staff noticed this without being asked and provided practical action to relieve distress and discomfort. For example when one person began coughing staff immediately responded and offered support. When another person became distressed and believed staff were angry with her a carer immediately reassured her that nobody was angry with her and sat for a short period of time to provide reassurance.

People told us that they were fully involved in their care and that they were confident in making their views known. They said they were treated with compassion, dignity and respect and they were involved in decisions about their care. They told us that meetings had taken place where they were able to discuss what they liked and what they did not like. People's relatives told us that they were involved in planning the care of their relative and that they were kept informed of any changes to their needs. One person said, "I had a discussion with the doctor and the matron when I arrived here from the hospital." A relative said, "Care package, it was me, my daughter, the manager and the social worker and everybody had input and the package worked out including medication and the doctor."

People told us that they usually had the privacy they needed. People chose whether to keep their bedroom doors open or whether they wanted them closed for privacy during the day. We noted that staff always closed bedroom doors when providing people's personal care to protect their dignity. One person who had their bedroom door open had a screen between the door and the bed to protect them from the view of anybody passing by. However, one person said, "At night I have gotten used to having the door open and if you close it they open it …….. with the door open you hear the snoring but you get used to them wanting the door open to check on you." This meant that people may not always get the privacy they wanted at

night.

Relatives told us they were free to visit at any time and were made welcome by staff.

Requires Improvement

Is the service responsive?

Our findings

Our inspection of 27 January 2015 found that the service required improvement in the activities it provided to people. At this inspection we found that some improvement had been made for more independent people however, improvement was still needed for people living with dementia.

People did not always receive their care or spend their time in the way their care plan and assessments described. Examples included one person sitting in front of the television with the sound turned down. Their care plan recorded, 'always ensure that the TV is on when [person] in the sitting room, ensure that the volume is at the level that [person] can hear.' When we checked with staff they were unable to explain why the television sound was not on for them. Another person's care plan stated that staff should not prompt them to join in activities, we observed staff approaching the person saying, "Wakey, wakey," and putting a bean bag in their hand. The person looked annoyed and threw the bag down by their side.

The impact of activities in communal areas had not been considered. Some people did not want to join in and we observed two people whose reactions were negative and they did not want to engage with staff or others. The activities being provided were disjointed and not always relevant to people's interests to support people's mental wellbeing which may have added to these reactions. Staff could not tell us about activities that individual people living with dementia responded well too. They had not explored different approaches or considered activities which might stimulate people in different ways and help make decisions about how people wanted to spend their day. For example, one person's care plan contained a letter from the hospital following a dementia review stating that when they became distressed distraction techniques worked best. Their social care plan stated they liked housekeeping. When this person became distressed staff did not use their interest in housekeeping as a distraction technique. Neither were the activities this person was being asked to participate in linked to their past history of enjoying housekeeping.

Opportunities to explore how staff could support people with complex needs to spend their time were not taken. We discussed one person's situation with the registered manger. They were unable to satisfactorily explain why suggestions made by professionals had not been fully acted on or why the person's care plan did not reflect their assessed interests. Where activities had been recorded as being enjoyed by the person this was not then used as a trigger to help further develop their care plan and put in place arrangements for this to be met.

The registered manager told us that they arranged meetings to discuss issues as they arose, for example Christmas entertainment and outings. One person told us they had been to a relatives meeting last year and had attended the Christmas and summer party. Regular meetings were not held to ensure that people and their relatives could participate in the direction the service was developed. A newsletter was available to people to keep them up to date with developments in the service.

The service had a complaints procedure which was displayed in the reception area. People told us they knew how to make a complaint and would do so if they felt it was necessary. We were unable to test the effectiveness of the way in which the service used these to improve the service because there had been no

complaints.

Requires Improvement

Is the service well-led?

Our findings

Our inspection of 27 January 2015 found that the leadership of the service did not set a good example by speaking in an appropriate way that would show respect to the people who used the service, their relatives and staff. The provider (one of whom is also the registered manager) had produced an action plan detailing how they would reflect on this practice and improve. At this inspection we found that some improvement had been made but there were still inconsistencies. One person told us, "The manager, she is a nice lady and she pops in now and again and if I am in reception when I read the paper I pop in and have a chat." Another person said, "….and I feel free to approach anyone at any time." However, one relative describing a recent incident said, "….and the manager had all the staff into her office and was hollering and shouting at them…." Staff told us that the manager did not always treat them with respect in front of people and on occasions shouted. However, they went on to describe how the manager was very supportive in other ways. People and staff demonstrated a respect for the manager's professional knowledge, but there were still concerns in the manner in which they demonstrated the values of the service. This meant that the culture could be improved to support the overall quality of the service.

The registered manager was not able to demonstrate how they ensured that they and the service were up to date with best practice and explored ideas for continuous improvement. For example some policies and procedures were not up to date and there was no system in place that would ensure updates were identified in a timely manner and put into practice. The services approach to dementia care did not reflect best practice guidance. As a result the leadership team were unable to demonstrate how they strived to improve and ensure the best quality care for those people they provided care for.

Feedback from people was not used for the purposes of continually evaluating and driving improvement within the service. For example a recent survey identified concerns about an unpleasant smell in the service. The service newsletter had referred to this as an issue that was continually being addressed by staff. However, inspectors noted that the unpleasant smell was still present in the service and there was no information about how this problem was being monitored and assessed to ensure improvement was made and sustained. No action plan was available in the service to demonstrate how the matter was being tackled differently to address the issue and stop it from re-occurring.

Records showed that regular audits of cleaning and maintenance of the service were carried out. However, these audits were not effective. With regard to the cleaning audit we observed plug holes in people's bedrooms with hairs in, sink taps with lime scale and dirt and dirty sink overflows. With regard to maintenance we saw curtains that were detached from the track, a wobbly chair and observed that roof lights, designed to allow light into darker corridors were not working effectively. . This demonstrated that these audits were not effective in checking that cleaning and maintenance had been carried out.

The quality assurance systems within the service were not robust to identify shortfalls in the quality of the service being provided. The service had become isolated which meant that it was unable to independently identify shortfalls and keep up to date with current best practice. We are concerned about the lack of drive for improvement within the service which is reflected in the ratings and breaches within this report and our

previous report.

This was a breach of Regulation 17 (2) (a) (e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The signage and decoration of the service did not meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and timely records were not being made. The service did not assess, monitor and improve the quality of the service provided and did not act on feedback received for the purpose of continually improving the service.