Broughton House - Home for Ex-Service Men and Women

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Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection carried out on 11 December 2015.

Broughton House is registered with the Care Quality Commission (CQC) to provide nursing, personal care and accommodation for a maximum of 50 ex-service men and women and is a registered charity. The home is situated in a residential area of Salford. There are car parking facilities to the front and side of the building. The home has an array of military memorabilia on display with a military museum on the first floor. There are spacious, well-kept garden areas surrounding the building and a separate entrance that had full ramp access for wheelchair users.

Summary of findings

There was a registered manager in place at the time of our inspection. 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.

When we last inspected this service in April 2014, we did not identify any concerns with the service.

During our inspection, we found three breaches of two Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), in relation to risk assessments, medication and record keeping. You can see what action we told the provider to take at the back of the full version of this report.

We found that initial risk assessments on admission were generally complete. However, we found examples where risks were identified with no action taken to reasonably mitigate such risks. One example related to an individual who chose to spend most of their time sat on their own in the home. This individual was of a different cultural background to the majority of people living at the home. We found at least one other person who used the service had been identified as having racist opinions and had previously racially abused members of staff. Though we found risk assessments in place to protect this individual against harm, there was no mention of how the home would protect them from potential racist abuse.

In another example, we found a person who had recently been admitted to the home, had been identified as having had poor eyesight, suffered from vertigo and confusion. This person was identified as requiring the support of walking aids, but often forgot to use them and did not recognise the dangers of mobilising without them. We found that this person had been allocated a bedroom on the first floor of the home. The room was directly next to the stairwell. The nurse completing the care plan had identified that the location was not ideal, but was awaiting a room becoming free on the ground floor. There was no evidence that the risks identified had been effectively addressed or had been discussed with the person who used the service or their family.

When viewing the care plan of one person who suffered from three serious illnesses, their records failed to identify how these illnesses should be managed safely. In particular, the problem relating to one illness talked about staff observing for symptoms, however it did not explain what these were.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), safe care and treatment, because the service had failed to demonstrate that they had taken all reasonably practicable steps to mitigate any identified risks.

As part of the inspection we checked to see how the service managed and administered medication safely. We found people were not always protected against the risks associated with medicines, because the provider did not have appropriate arrangements in place to manage medicines safely. In four records we looked at relating to the administration of prescribed creams we found repeated gaps and omissions. This meant the service could not demonstrate that the medication had been administered in line with the prescription.

We found an example when the home had run out of a prescribed medication for a person who used the service. We were told that the pharmacist had not delivered the correct amount, which meant the person did not have their medication administered for two nights. We spoke with the person who used the service who told us that sometimes there were delays in getting their medicines. They had run out of medication last Sunday and no explanation was provided by the home as to why they didn't have enough stock.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), safe care and treatment, because the service failed to ensure sufficient supplies and the proper and safe management of medicines.

We found that care plans did not always accurately reflect people's current needs. The service used two sets of care files for each person who used the service. One was paper based and the other was an electronic record. We repeatedly found information in paper files, which was either out of date or missing. The potential existed for a member of care staff to act on wrong or missing information if referring to the paper files for instructions relating to an individual's care

Summary of findings

People and their relatives told us that the home was responsive to their needs and they were involved in deciding the care they or their loved one's received, however this was not clearly documented in care files we looked at.

We found that for some people lacking capacity to make specific decisions for themselves there was no clear, readily accessible record of what had been done to assess this need and the outcome. We found that a facility existed on the MCA electronic file for this to be recorded, however we found that in some instances fields had not been populated. We also found examples that risk assessment and care plan review dates were either missing or out of date.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), good governance, because the service had failed to maintain accurate and complete contemporaneous records for people who used the service.

We found people were protected against the risks of abuse, because the home had appropriate recruitment procedures in place. Appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults.

We found the home had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse.

We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. During our visit we found there were sufficient numbers of staff on duty during the day to support people who used the service. When we spoke with staff we received conflicting views regarding staffing levels. On the whole, nurses told us that they felt staffing levels were sufficient, whereas most care staff felt the home was often under staffed.

Staff we spoke with said they received an induction when they started working at the home, which included classroom based training and shadowing more experienced staff.

All staff we spoke with confirmed they received supervision and appraisals, which we verified by looking at supervision records and a supervision matrix.

At the time of our inspection, there were a number of people living at the home who were subject of a Deprivation of Liberty Safeguards (DoLS). The service monitored DoLS by use of a log, however we found that this record was incomplete as there were 14 names on the list with no information recorded.

Where it had been identified that people did not have capacity to make choices, then the appropriate requests for Deprivation of Liberty Standards (DoLS) were in evidence as well as best interest decisions.

Throughout our inspection, we observed staff seeking consent from people before delivering any care or treatment such as medication, support with mobilising, personal hygiene or support with eating.

We have made a recommendation about 'dementia friendly' environments.

The home undertook an initial assessment to identify any dietary and nutritional needs. We looked at food and fluid intakes charts, which were reviewed on a regular basis.

Staff were complimented on the way they approached and cared for people who used the service.

Throughout our inspection, where we observed interaction between staff and people who used the service, it was kind, appropriate and caring. People looked clean and well groomed. Staff knew people well and there was a friendly atmosphere between staff and people living at the home.

The home was also a member of 'Care Aware Advocacy Service,' which was a 'one stop shop' for people and families to seek independent advice and support.

During our inspection, we checked to see how people were supported with interests and social activities. We found that the home had a dedicated activities co-ordinator, who was also the Welfare Officer. People we spoke with were able to describe a comprehensive list of activities they could join in within the home, which included outings to engage in various social events.

We found that the service routinely listened to people to address any concerns or complaints.

While nurses told us they were supportive of the new manager, a number of care staff we spoke with felt there was a 'disconnect' between the registered manager and care staff who were very unhappy. We were told that the

Summary of findings

management team were rarely seen on the floor. They told us that they did not feel valued or listened to by the registered manager. Other care staff felt the registered manager was approachable and that the changes made had been on the whole positive and had contributed to improving the home.

We spoke to the registered manager about these concerns, who demonstrated a clear vision of the changes that were required. They acknowledged that there had been some unhappiness with some staff in relation to working practices and the changes implemented since their arrival and that some staff had left the service. The manager told us that they felt communication between management and staff needed to improve in order to successfully implement the changes they proposed.

We found the service undertook an extensive and comprehensive range of audits and checks to monitor the quality of services provided. However, we questioned the effectiveness of some of these audits in light of the issues we found in respect of medication, risk assessment and the quality of record keeping within care files.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

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?

Not all aspects of the service were safe. We found that initial risk assessments on admission were generally complete. However, we found examples where risks were identified and no action taken.

We found people were not always protected against the risks associated with medicines, because the provider did not have appropriate arrangements in place to manage medicines safely.

We found the home had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse.

Requires improvement

Is the service effective?

Not all aspects of the service were effective. Staff we spoke with said they received an induction when they started working at the home, which included classroom based training and shadowing more experienced staff.

We found that information relating to MCA, DoLS, risk assessment and care plan review dates was either missing or out of date.

We have made a recommendation about environments.

Requires improvement

Is the service caring?

We found the service was caring. Staff were complimented on the way they approached and cared for people who used the service.

Staff knew people well and there was a friendly atmosphere between staff and people living at the home.

The home was also a member of 'Care Aware Advocacy Service,' which was a 'one stop shop' for people and families to seek independent advice and support.

Good

Is the service responsive?

Not all aspects of the service were responsive. We found that care plans did not always accurately reflect people's current needs.

People we spoke with were able to describe a comprehensive list of activities and opportunities they could join in within the home.

We found that the service routinely listened to people to address any concerns or complaints.

Requires improvement

Summary of findings

Is the service well-led?

Not all aspects of the service were well-led. While nurses told us they were supportive of the new manager, a number of care staff we spoke with felt there was a 'disconnect' between the registered manager and care staff who were very unhappy.

We found the service undertook an extensive and comprehensive range of audits and checks to monitor the quality of services provided. However, we questioned the effectiveness of some of these audits in light of the issues we found in respect of medication, risk assessments and the quality of record keeping within care files.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

Requires improvement

Broughton House - Home for Ex-Service Men and Women

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection checked whether the provider 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 11 December and was unannounced. The inspection was carried out by two adult social care inspectors, two specialist advisors and an expert by experience. A specialist advisor is a person with a specialist knowledge regarding the needs of people in the type of service being inspected. Their role is to support the inspection. The specialist advisors were a nurse with experience of elderly/older person care and a social worker with experience in supporting military veterans and elderly/older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the home. We reviewed statutory notifications and safeguarding referrals.

We also liaised with external professionals including the local authority, local commissioning teams and infection control. We reviewed previous inspection reports and other information we held about the service.

At the time of our inspection there were 41 people living at the home. We found that there were 16 people receiving nursing care and 24 people receiving residential care. One person was also receiving temporary respite care. We spoke with 14 people who lived at the home, four relatives and three visiting health care professionals.

At the time of our inspection, the home employed a total of 78 staff. We spoke with three nurses, which included one agency nurse. We spoke to eight members of care staff, which included two agency staff, two domestic cleaners, the chef, the activities coordinator, a care administrator, a support manager and the registered manager. The registered manager was present throughout the inspection. We also spoke to a representative of the Trustees for the home.

Throughout the day, we observed care and treatment being delivered in communal areas that included lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. We looked at people's care records, staff supervision and training records, medication records and the quality assurance audits that were undertaken by the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with consistently told us that they felt the home provided a nice environment and many felt that it was an excellent home to live in. They told us the home was kept clean without any unwanted odours. Comments from people who lived at the home included, “It is home. It is wonderful." "I'm as happy as I can be." "The people who visit me are very impressed by the place." "I like it here. There is nothing I would change. I am very happy, on top of the world." "They keep the place very clean." "It's not bad at all." "I think it's an excellent home." "It's good compared with homes I've been in. Of the three homes I've been in this is the best."

One visiting relative who we spoke with told us, “It's brilliant, superb. The carers are fantastic with him. It's always spotlessly clean." Another relative said "It's a lovely place. There is nothing wrong with it." Comments from other relatives included, "This home is splendid. It's one of the better ones I've visited. The staff are very nice. It's kept very clean here." “All in all pretty good. He is safe here.”

One visiting health care professional told us, that they thought it was a good home compared to others they visited. They also said they had never had a problem here with the home and that the residents always look cared for and happy.

We looked at a sample of 12 care files to understand how the service managed risk. We found the service undertook a range of risk assessments to ensure people remained safe. Risks were assessed using nationally recognised tools and included areas such as nutrition, skin integrity, communication, cognition, mobility, breathing, elimination and personal hygiene.

We found that initial risk assessments on admission were generally complete. However, we found examples where risks were identified with no action taken to reasonably mitigate such risks. One example related to an individual person who chose to spend most of their time sat on their own in the home. This individual was of a different cultural background to the majority of people who lived at the home. We found at least one other person who used the service had been identified as having racist opinions and had previously racially abused members of staff. Though we found risk assessments in place to protect this individual against harm, there was no mention of how the home would protect them from potential racist abuse. When we spoke to staff about this issue, they told us they did not feel that there had been any previous issues as regards racial abuse involving this person. They therefore felt there was no need for such a risk assessment.

In another example, we found a person who had recently been admitted to the home had been identified as having had poor eyesight, suffered from vertigo and confusion. This person was identified as requiring the support of walking aids, but often forgot to use them and did not recognise the dangers of mobilising without them. This person had been allocated a bedroom on the first floor of the home. The room was directly next to the stairwell. We found the nurse completing the care plan had identified that this location was not ideal, but was awaiting a room becoming free on the ground floor.

We spoke with staff about this concern who explained that the person liked his upstairs room and that the family had requested that their relative remained in that room. We found no evidence of these conversations in records we looked at. There was no evidence that the risks identified had effectively addressed or had been discussed with the person who used the service or their family. One member of night staff told us that this person was subject of hourly night checks as they wandered. They believed the person was risk of following down the stairs and that they should be located downstairs for their own safety.

In another example we found, a person who suffered from three serious illnesses, their records failed to identify how these illnesses should be managed safely. In particular, the problem relating to one illness talked about staff observing for symptoms, however it did not explain what these were. When we spoke with staff it was clear that a great deal of discussion had taken place with the specialist mental health team, however little of this had been documented.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), safe care and treatment, because the service had failed to demonstrate that they had taken all reasonably practicable steps to mitigate any such risks identified.

As part of the inspection we checked to see how the service managed and administered medication safely. We found

Requires improvement

Is the service safe?

people were not always protected against the risks associated with medicines, because the provider did not have appropriate arrangements in place to manage medicines safely.

Controlled Drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were checked and found to be correct. The stock was minimal and their were sufficient to meets people's current needs. Where medicines required cold storage, daily records of temperatures were maintained.

We found that records supporting and evidencing the safe administration were not always complete and accurate. We looked at a sample of 11 medication administration records (MAR), which recorded when and by whom medicines were administered to people who used the service.

In four records we looked at relating to the administration of prescribed creams we found repeated gaps and omissions. This meant the service could not demonstrate that the medication had been administered in line with the prescription.

In another example, we found a MAR documented the use of a prescribed body wash. No entries had been made demonstrating administration. We found an entry that stated 'not in room' dated 23 September 2015. No further checks were made until 08 December 2015 when medication was still not available. We spoke to the nurse as to why the medication was not available. They subsequently told us the medication had never been prescribed and that an error had been made on the MAR. No recorded action had been taken since September by staff to address the availability of medication or identify that it had been entered on the MAR in error.

We found an example when the home had run out of a prescribed medication for a person who used the service. We were told that the pharmacist had not delivered the correct amount, which meant the person did not have their medication administered for two nights. We spoke with the person who used the service who told us, that sometimes there were delays in getting their medicines. They had run out of medication last Sunday and no explanation was provided by the home as to why they didn't have enough stock.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), safe care and treatment, because the service failed to ensure sufficient supplies and the proper and safe management of medicines.

We found people were protected against the risks of abuse, because the home had appropriate recruitment procedures in place. Appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection we looked at 10 staff personnel files. Each file contained job application forms, employment history, proof of identification, a contract of employment and suitable references. A CRB or DBS (Criminal Records Bureau or Disclosure Barring Service) check had been undertaken before staff commenced in employment. CRB and DBS checks help employers make safer recruiting decisions and prevents unsuitable people from working with vulnerable adults.

During the inspection we checked to see how people who lived at the home were protected from abuse. We found the home had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. We found that all staff had received safeguarding training and received regular updates. Staff we spoke with were confident that they could identify safeguarding issues and could knew where concerns should be reported to, both internally within the home and externally if required.

One member of staff told us, "With safeguarding, I would go straight to the line manager and report concerns. If they failed to take action I would contact safeguarding directly." Another member of staff said "There is no oppressive or bullying culture here. I feel I can be open and honest." Other comments from staff included, "I have had experience of reporting people for safeguarding concerns. I would have no hesitation in reporting anything. I'm confident management would deal with it, if not I would report it directly myself."

We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. During our visit we found there were sufficient numbers of staff on duty during the day to support people who used the service. Staffing numbers consisted of two nurses plus eight care staff during the day and one nurse and four care staff at night. Additionally, during the day

Is the service safe?

there were two managers, an activity coordinator, as well as administrative support, catering and domestic staff. We were told by management that the service relied on agency staff particularly at night time, but were currently in the process of recruiting full time staff.

We looked at staffing rotas and spoke to the manager, about how staffing numbers were determined. The manager, who is a registered nurse, told us that they did not use a dependency tool to determine staffing requirements and the current staffing levels were determined by their professional judgement. The manager told us they would consider introducing a dependency tool to assist in accurately determining the correct numbers of staff required. The registered manager explained that the home was about to begin a period of change for the nursing and care staff as they embarked upon a four week rolling rota. This would provide for a greater ability to long term plan and ultimately improve the work life balance for staff.

We spoke with people who used the service about staffing levels. One person who used the service said “They always have the same number of staff on. I've never seen it understaffed. “Another person who used the service told us, "We've got buzzers in the room. The staff come very quickly." One relative told us, "Sometimes they employ agency staff. Staff spend a lot of time telling them what to do." Another relative said “Reasonably staffed, but a bit thin on the ground at weekends.”

When we spoke with staff we received conflicting views regarding staffing levels. On the whole, nurses told us that they felt staffing levels were sufficient, whereas most care staff felt they were often under staffed. Comments from staff included’ “Staff have left, staff are not happy with management. They don’t get on with management.” “Residents are 100 percent safe here and there is enough staff at nights.” “I don’t think the current staffing at nights is enough at all. The ratio is not correct. There are lots of men who are very demanding and wander. I think an extra carer would make a difference.” “Usually staffing levels are ok. My only concern it is a very heavy work load for one nurse at nights.” “People are safe with current staffing levels.” “At nights there has been a big reliance on agency staff, but things are improving.” “Someday we have only five care staff and are short staffed and can’t meet people’s needs. I wouldn’t choose this place, we are short staffed.” “When I have raised short staffing in the past, management say there is enough staff.” “Care staff during the day is most of the time four. We are always short and agency don’t know residents. The registered manager doesn’t even know the residents.”

Requires improvement

Is the service effective?

Our findings

As part of this inspection we looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. Staff we spoke with said they received an induction when they started working at the home, which included classroom based training and shadowing more experienced staff. Staff were also required to complete the Care Certificate programme, which provided a comprehensive introduction to adult social care. Senior staff were able to confirm they received regular training to support their own individual professional development, which we verified from looking at training record. In addition, the registered manager confirmed that the home provided annual mandatory training including annual practical training in manual handling for all staff.

Comments from staff included, "I get a lot of training, I have just done end of life as part of the 'six step programme.' I have also completed refresher training in safeguarding, emergency first aid, manual handling and infection control, which was a one day course." "I have had training in end of life, safeguarding, manual handling. I have had no recent training in mental capacity act, but covered these areas in my National Vocational Qualification (NVQ)." We found that a number of staff had undertaken NVQ training in social care at both level two and three.

All staff we spoke with confirmed they received supervision and appraisals, which we verified by looking at supervision records and a supervision matrix. Supervisions and appraisals enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner. Comments from staff include, "I have supervision with either the registered manager, the deputy manager or lead nurse, it's about every six months or so." "Yes I feel supported and get regular supervision."

The registered manager explained they were actively pursuing the possibility for internal promotion opportunities for staff to enhance their knowledge, scope and responsibility. The manager also stated that they had encouraged staff members to seek out education for career advancement where possible. This meant the service actively encouraged staff development to ensure they were suitably trained and competent to undertake their roles.

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. At the time of our inspection, there were a number of people living at the home who were subject of a Deprivation of Liberty Safeguards (DoLS). The service monitored DoLS by use of a log, however we found that this record was incomplete as there are 14 names on the list with no information recorded. The nominated lead for MCA/DoLS and Safeguarding was on leave at the time of the inspection. We were shown a screening tool used by the home to prioritise requests to authorise a Deprivation of Liberty.

We found where it had been identified that people did not have capacity to make choices, then the appropriate requests for Deprivation of Liberty Standards (DoLS) were in evidence as well as best interest decisions. We found that information relating to MCA, DoLS, risk assessments and care plan review dates was either missing or out of date. On speaking to staff and despite previous training, their understanding of the principals Mental Capacity Act 2005 was limited.

We spoke to the registered manager who explained that since their appointment they had identified a number of areas of practice and processes, which required overhauling. This included the MCA and DoLS, which they described currently as 'work in progress'. The registered manager acknowledged that there was a deficit in training needs for all staff in relation to the MCA and as a result, had organised training for all staff to commence in January 2016. In respect of the MCA/DoLS, the registered manager told us they had also identified the underuse of the electronic data system for recording purposes. Their focus on maximizing the full potential of the electronic data system would provide a more coherent, concise and safe platform by which to deal with the principals of this legislation.

Throughout our inspection, we observed staff seeking consent from people before delivering any care or treatment such as medication, support with mobilising, personal hygiene or support with eating. We found that staff took time to speak to people and explain what they wanted to do. One member staff told us' "We know people

Is the service effective?

here, with consent and with people who have difficulty communicating, I use hand signals or write things down. I always tell them what I want to do. I wouldn't do anything unless they consented."

We found people had access to healthcare professionals to make sure they received effective treatment to meet their specific needs. The home maintained good working relationships with the pharmacist, local GP practices, NHS teams from the local district general hospital, community mental health teams, district nurses and Infection control, however interaction was not always clearly recorded in the care files.

The adaptation, design and decoration in the home was generally of a good standard. However, we found the home did not have adequate signage features that would help to orientate people living with dementia. Doors were wood stained doors with small brass name plates, which would be difficult for anyone to read with failing eyesight. Confused residents would find it difficult to locate their individual rooms or the toilet. We saw little evidence of dementia friendly resources or adaptations in any of the communal lounges, dining room or bedrooms. This resulted in lost opportunities to stimulate people as well as aiding individuals to orientate themselves within the building.

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

During our inspection we checked to see how people's nutritional needs were met. Comments from people who used the service included, "There is always a choice for food. If you ask for something specific they will do it for you." "The food is very good, well prepared and good food. We get a cooked breakfast and lunch and sandwiches at dinner, sometimes it's cooked." "It's ok. The food is good. My favourite is fish and chips." "The breakfast is usually very good. It's cooked, egg and bacon." "There is plenty of food." "The food is alright. I get sufficient food. My favourite is omelette or chicken curry. They do that for me." "You get a choice with the food."

The home undertook an initial assessment to identify any dietary and nutritional needs. We looked at food and fluid intakes charts, which were reviewed on a regular basis. The home offered a well-balanced and nutritious diet, served in an appropriate manner by staff. Support was offered to people who have difficulties in eating and drinking when it was required. We observed one person who used the service falling asleep over their lunch. We saw two members of staff who on separate occasions prompted this person to eat. This person was initially unwilling to eat, but with the gentle prompting by staff this person began to eat albeit slowly. This person was not rushed or hurried by staff. The meal time experience was calm and conducted in a happy environment.

We spoke to the chef, who told us that the new manager had introduced 'take away and pizza nights,' which had been a great success and would be repeated. The new manager had been instrumental in the refurbishment of the cold room and freezer. The kitchen was clean and tidy, which we were not allowed to enter until we had washed our hands and donned a hair net and disposable protective gown.

There was a comprehensive board displaying special dietary requirements and allergies for a number of people who used the service. Special diets catered for people's cultural or religious needs. Menus were completed two weeks in advance and the menus we viewed for the forthcoming two weeks were nutritious and varied. However, during lunch we found the displayed menu did not accurately record what was on offer for people. Where the menu stated that the dessert was to be sultana sponge and custard, we saw that people were offered a choice of jelly or crème caramel. Special diets were also catered for including any related to the person's cultural or religious needs.

Good

Is the service caring?

Our findings

Staff were complimented on the way they approached and cared for people who used the service. People told us that staff were conscientious and treated people with dignity and respect. One or two were specifically named as being caring and supportive. One visitor was particularly impressed with the knowledge of staff concerning residents, their needs and the best way to support them. One person who used the service told us, "The staff are marvellous. They are friends." Another person who used the service said “The carers are conscientious. They treat you in a proper manner. They have the right attitude."

Other comments from people who used the service included, “The staff look after you." "I find the staff are very good." "You are well looked after here." "All the nurses are good. Cheeky, but good." "The carers look after you, especially X, she's a nurse." "The carers are pretty good here. They look after me, they are very good, not all of them but most." "The nurses and carers are, by and large, very good." "The home is very good and the carers." "The staff are friendly. There are no bad staff here."

One visiting relative told us, "He's happy here. He says to me that he is well looked after." Another relative said "They looked after my husband really well." Other comments from relatives included "X, he's a good lad. He gets things done." “Staff are genuine and caring.” One visitor told us they were particularly impressed with the knowledge of staff concerning residents, their needs and the best way to support them. Another visitor told us they felt very welcomed at Broughton House and said that whilst they come at least once a week, they knew that they could call at any time. They felt their relative had been well cared for whilst staying at the home and described Broughton House as being a ‘family’.

Throughout our inspection, where we observed interaction between staff and people who used the service, it was kind, appropriate and caring. People looked clean and well groomed. Staff knew people well and there was a friendly atmosphere between staff and people living at the home. Staff exhibited patience and spoke to the person gently explaining what they wanted them to do or where they wanted them to go. We observed other staff joking with people and taking the time to talk to them.

As part of the inspection we checked to see how people’s independence was promoted. We asked staff how they aimed to promote people’s independence. One member of staff told us, “Promoting independence is important. A lot of the men here are independent, but there is one chap in particular that will respond positively to support and encouragement to be more independent and is happy to do things for himself like washing and dressing.” Another member of staff explained how they had encouraged a person to walk independently using a walking frame, however the person’s family were inclined to use a wheel chair. They explained how they had also encouraged the family not to rely on the wheel chair and to encourage the use of the walking frame.

Though some people told us they were involved in making decisions about their care and were listened to by the service, this was not always documented clearly in care files. The home had a residents’ committee, where people were encouraged to express their wants and needs. The home sent out quality assurance questionnaire for people to complete in relation to the quality of care provided. Additionally, people and their families were asked in a ‘family and friends test,’ whether they would recommend the home.

The home was also a member of ‘Care Aware Advocacy Service,’ which was a ‘one stop shop’ for people and families to seek independent advice and support. This included advice on social service assessment procedures, assessing support of local support groups and end of life wishes in respect of enduring/last powers of attorney.

Requires improvement

Is the service responsive?

Our findings

As part of this inspection we 'case tracked' 12 people who used the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and wellbeing were being appropriately managed by the service. We found that care plans did not always accurately reflect people's current needs.

The service used two sets of care files for each person who used the service. One was paper based and the other was an electronic record. We repeatedly found information in paper files, which was either out of date or missing. The potential existed for a member of care staff to act on wrong or missing information if referring to the paper files for instructions relating to an individual's care. From speaking with staff, there was no clear guidance as to who was responsible for ensuring the paper files were up to date and accurately reflected people's current needs.

People and their relatives told us that the home was responsive to their needs and they were involved in deciding the care they or their loved one's received, however this was not clearly documented in their care files we looked at.

We found that for some people lacking capacity to make specific decisions for themselves there was no clear, readily accessible record of what had been done to assess this need and the outcome. We found that a facility existed on the MCA electronic file for this to be recorded, however we found that in some instances fields had not been populated. We found examples that risk assessment and care plan review dates were either missing or out of date.

We were told all care staff had access to electronic tablets, which synchronised automatically with the data base and vice versa, thus meaning that all electronic records had the potential to be contemporaneous and up to date. Each resident had a 'Who am I' folder on their electronic file, which held information about that person's likes, dislikes and interests for example. Whilst some these folders were correctly populated, others had very limited information.

From speaking to staff and reading entries on the electronic records it was clear that care was being delivered, however it was difficult to determine how responsive staff were to meeting an individual's needs just by examining the entries. Staff were able to tell us about engagement with external health care professionals in meeting people's specific needs, however this was not always clearly recorded in paper or electronic files.

We spoke to the registered manager about these concerns, they identified the underuse of the electronic data system for recording purposes and that these concerns would be addressed as part of their improvements programme.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), good governance, because the service had failed to maintain accurate and complete contemporaneous records for people who used the service.

During our inspection, we checked to see how people were supported with interests and social activities. We found that the home had a dedicated activities co-ordinator, who was also the Welfare Officer. People we spoke with were able to describe a comprehensive list of opportunities they could join in within the home, which including outings to engage in various social events. The home had a bar, which opened for two hours every day. People were routinely asked to attend formal lunches and dinners, taking place as guests of honour at many military events.

The home also supported people to attend annual garden parties held at Buckingham Palace, on behalf of 'The Not Forgotten Association'. Summer and Christmas Fayre's were also undertaken. On a monthly basis a themed event with an outside performer took place, which was open to the wider community and families. During our inspection, Christmas tree and decorations were evident and preparations were underway for a Christmas party, which took place that afternoon. It was attended by two singers who performed for people and their families in the main lounge, during which refreshments were provided.

One person who used the service said "The Welfare Officers organises trips out to the pub. She is very obliging." Another person who used the service told us, "If you want something. You only have to ask." Other comments from people who used the service included, "You can go to the pub, The Red Lion, once a week. We go most weeks." "We're very lucky. They take us out, to Liverpool, to the pub about once a week and we go fishing in the good weather. We play Ludo and all sorts of other things and we have

Requires improvement

Is the service responsive?

painting lessons." "There is plenty to do. I have been out to a museum in Manchester." "I take the newspapers round in the morning." "We go to the Red Lion on a Thursday. We went to the races at Haydock Park. We go bowling."

Comments from families included, "They have bingo. They take them out a lot too. There's a bar open four times a week. It's a good thing, for social things." "It's like an extended family. They are so good. I come to have my dinner with them every Friday." "There is entertainment once a month on a Friday." "They have a Sunday service in the library." One visiting health care professional told us that their patient was very happy at the home and that there were always activities on when they visited.

We found that the service routinely listened to people to address any concerns or complaints. We found the provider had effective systems in place to record, respond to and investigate any complaints made about the service. One person who used the service told us, "I have never had to complain about anything, once." Another person who used the service said "They make it clear, if you have a complaint do something about it." Other comments included, "If I had a complaint I would mention it to staff and ask her to pass it on to the matron."

The service were able to demonstrate 'lessons learnt' from any complaints, safeguarding or incidents, which was then used to improve the quality of care and treatment provided. One example we were shown related to the admission process involving none clinical staff. This had resulted in care that fell below the expectations of the person and their family. The registered manager explained how the admission process had been reviewed as a result and procedures changed to ensure only clinical staff undertook pre-admission assessments. This meant the service endeavoured to learn from failings in order to improve the quality of services it provided.

Requires improvement

Is the service well-led?

Our findings

At the time of our visit, the registered manager had just registered with CQC in October 2015 and had been in post since May 2015. 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.

During our inspection, we spoke to people who used the service and staff regarding what they thought about how well managed the service was. One person who used the service told us, "The matron is very pleasant, she keeps a quiet profile." Another person who used the service said "The new matron seems to have sorted them out. She definitely knows what's going on. She's adapted things to suit us. She comes down to help if it's needed. She comes down to the bar to talk to people."

Other comments from people who used the service included, "I'm a little disappointed that some good nurses and carers have moved on. One or two have said to me that they can't work here anymore." "I've only seen her (matron) once. The old matron got things done straight away." "There's nothing I would change about the home." "The new matron is alright, in small pieces." One visiting relative told us, "It seems to be running well with the new matron." A visiting health care professional us that this was their second visit and their impressions were very good. The service was a lot more organised and seemed to be a lot calmer than before.

Prior to our inspection, we had received information suggesting that night staff had been directed to wake people up in the morning and to get them dressed and washed, whether the person consented or not. On the day on the inspection, we attended the home at 0630am and on our arrival found eight people sat in the in the ground floor lounge, being offered a drink by the night nurse. We spoke to each person who confirmed that it had been their choice to get up at that time.

While nurses told us they were supportive of the new manager, a number of care staff we spoke with felt there was a 'disconnect' between the registered manager and care staff who were very unhappy. We were told that the management team were rarely seen on the floor. They told us that they did not feel valued or listened to by the registered manager. Some felt the approach of the manager was occasionally overbearing and rude and the changes introduced had been detrimental to staffing levels, particularly during the morning. Some care staff told us that a number of experienced staff had left the home as a result.

Other care staff felt the registered manager was approachable and that the changes made had been on the whole positive and had contributed to improving the home. One member of care staff said that they thought the registered manager was very direct, however the staff that had left the home had needed to go as they weren't performing.

We spoke to the registered manager about these concerns, who demonstrated a clear vision of the changes that were required. They acknowledged that there had been some unhappiness with some staff in relation to working practices and changes implemented since their arrival and that some staff had left the service. They told us that since coming into post they were aware that there were a number of areas of practice and processes that required improvements and currently described the position as a home as 'work in progress'. The registered manager told us that they felt that communication between management and staff needed to improve in order to be able to successfully implement the changes they proposed.

We found the service undertook an extensive and comprehensive range of audits and checks to monitor the quality of services provided. These included weekly fire systems checks, medication audits, environmental checks, equipment and water checks, infection control, monthly clinical room, kitchen, laundry and food quality audits. A Care and Clinical Advisory Board had been established to independently review the quality of clinical care provided. Regular meetings were undertaken, which included meetings involving nurses, care staff, domestic, kitchen, maintenance staff and Health & Safety. However, we questioned the effectiveness of some of these audits in light of the issues we found in respect of medication, risk assessment and quality of record keeping within care files.

Requires improvement

Is the service well-led?

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service had failed to demonstrate that they had taken all reasonably practicable steps to mitigate any identified risks .**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service failed to ensure sufficient supplies and the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service had failed to maintain accurate and complete contemporaneous records for people who used the service**