Eastwood Hall Limited

Broadoaks

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Broadoaks is a residential care home providing personal care for up to 39 older people and people living with dementia in one adapted building. The building was split across two floors, each of which has separate adapted facilities. One of the floors specialises in providing care to people living with dementia. There were 16 people receiving a service at the time of our inspection.

People's experience of using this service and what we found
The provider did not have robust safety and quality monitoring processes in place. People's care records were not always up to date or completed appropriately, and the provider's management checks had not identified these gaps in recording.

Staffing levels were not assessed against a dependency tool to ensure that adequate levels of staff were deployed appropriately. Concerns were raised on quality visits conducted by the local authority. People were being left for periods of time in unstaffed areas of the service. The provider has since increased staffing levels to ensure all areas of the service are staffed at all times.

People received their medicines as prescribed and staff had clear information about how people liked to be supported with their medicines. Staff were knowledgeable about people's health needs and the provider had sought support from other health professionals as appropriate to support people's needs.

Staff wore appropriate personal protective equipment (PPE) and told us they knew how to minimise people's risk of infection through safe infection prevention and control processes.

Staff were safely recruited to the service, and were provided with relevant training for the roles they undertook. All staff training was up to date at the time of inspection.

The provider was , working with the local authorities to address concerns they had found.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 04 December 2018)

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and risks to people. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to governance and staffing levels at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Broadoaks

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by an inspector, and an inspection manager.

Service and service type
Broadoaks is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with five members of staff including the provider, registered manager, care workers, and activities co-ordinator. We used observations to gather evidence of people's experience of care.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- The provider did not use a calculation tool to determine what staffing levels should be against the current needs of the people using the service. We could not be assured that staffing levels were always adequate to ensure safe, quality care. We found staff were not always deployed effectively.
- We found people did not receive timely support from staff and at times people were left waiting. This placed people at risk of not having their needs met promptly.
- Night staff supported day staff to assist people in the morning with personal care. Staff told us, "A member of day staff arrives at 6:30am and night staff remain until 8am, so there are enough staff." However, care plans did not always state when people liked to be assisted with personal care and if they were given choice over what times they would like this support.

We found no evidence that people had been harmed. However, we were not assured systems were robust enough to demonstrate staffing levels were effectively managed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were recruited to the service safely, and in line with current best practice guidance.
- The provider had increased the amount of staff following concerns being identified by external stakeholders, however, as this was a very recent change we could not assess if this had led to improvements within the service.

Assessing risk, safety monitoring and management

- Risks to peoples safety were assessed. However, there was not always enough detail in peoples risk assessments about how staff should support people safely, or what staff should do to lower the risk.
- One person was identified as being medium risk of falls, being unsteady on their feet and showing distressed behaviours. They had for some time been left unsupervised by staff when distressed on the top floor. The registered manager told us they were no longer being left unsupervised, however care plans and recording of staff being with the person had not been updated to reflect the need or increase in care provided. Following inspection the registered manager updated this information.
- The provider conducted investigations into incidents that had happened at the service, such as unwitnessed falls. The investigations did not identify if any additional support or equipment would be required to prevent the incidents from happening again, and were just factual accounts of what had happened. This meant we could not be assured steps had been taken to mitigate future risks.

● Staff had access to information on how to support people who were showing signs of distress. This was documented within peoples care plans. However, this information was not always up to date, or reflective of the current processes in place within the service to support people showing signs of distress. This meant we could not be assured people were receiving the correct support when they needed it.
● Fire safety risks and considerations had been fully assessed. A full review of all fire safety procedures and evacuation plans had been completed in August 2021. Detailed plans were in place for evacuation from communal areas, as well as fire prevention and suppression methods for staff to safely use.
● People had Personal Emergency Evacuation Plans (PEEPs), these included details of how people could be evacuated safely, detailing mobility issues to consider, and how many staff members they would need.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems in place to safeguard people against abuse, however, these were not robust. We found instances where concerns were not reported correctly. Two service users had unwitnessed falls, resulting in injuries, that had not been reported correctly.
● Staff understood what to do if they had safeguarding concerns. This included how to 'whistle blow' to external bodies such as the CQC and local authority. One told us, "I have never had to raise concerns but feel comfortable to do so if I had them."
● All staff had received safeguarding training.

Using medicines safely
● People received their medicines as prescribed.
● There was a system in place for the safe management and administration of people's medicines. Staff were trained in medicines administration, and there were clear details in peoples care plans on how they liked to receive their medicines and what support they needed to safely take their medicines. For example, some people required a spoon. Senior staff administering medicines knew what the medicines were for and what side effects to look out for.
● Staff completed Medicines Administration Records (MAR) accurately.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

● We could not be assured that lessons were learned or shared with staff following incidents, as there was no details of changes or reviews following incidents. For example, a person had two unwitnessed falls resulting in injuries, however, nothing was updated within the care plans or risk assessments.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager was unclear on the requirements of reporting to CQC. We found instances where safeguarding concerns had been raised to the local authority, but CQC had not been notified. Following the inspection, the registered manager submitted notifications retrospectively to CQC.
- The registered manager could not demonstrate a clear understanding of MCA (Mental Capacity Act), and how capacity assessments should be applied to people who may be deemed to lack capacity to make decisions for themselves. However, following the inspection, the registered manager sought guidance and provided evidence that assessments were now being completed
- Staff were clear about their roles and how those roles affected the people being cared for.
- The providers governance and overview processes were not robust. They had not identified the issues we found on inspection, in relation to safeguarding, accident/incidents, falls or care documentation.
- Falls had been recorded, and investigation had been completed, this did not look at the cause of the falls, or analyse the overall reasons for falls. There were four unwitnessed falls during the month of August 2021, where the outcome was recorded as 'equipment already in place.'

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- It was not always clear if people were involved in the planning and decisions surrounding their care. Care plans did not always record that consent had been given by the person, or if consent had been provided by someone else, whether that person had Lasting Power of Attorney for that decision.
- The provider did not have systems in place to support decision making for people who may lack capacity to do so. We could not be assured that decisions made by the provider were in the persons best interest, and the least restrictive.
- Peoples care plans did not always give sufficient detail of how to support people who showed signs of distress or how to safely support people to mitigate risks following falls. We found language used in care plans did not meet best practice guidance.

We found no evidence that people had been harmed; however, the systems in place to monitor the quality and safety of the service were not effective. This placed people at risk of harm. This was a breach of

regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others; Continuous learning and improving care

- The provider worked well with external professionals, and sought guidance and advice on how to provide care to the people living in the service. We saw records of contact with district nurses, occupational therapy, and physio. This information was incorporated into people's care plans.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality and safety of the service were not effective. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of suitably qualified persons were deployed appropriately.