Broadoak Group of Care Homes

Broadoak Lodge

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 18 March 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Broadoak Lodge on our website at www.cqc.org.uk

We found that there were sufficient staff on duty to meet people's needs. People told us that there were times when they had to wait for staff to assist them but that there needs were attended to within a reasonable time.

People's care plans contained information about their life history and preferences. Relatives told us that people's preferences were respected and that their needs were being met.

People's care needs were assessed but they had not always been updated following any changes to people's needs.

We found that some people were having to use the shower facilities in other people's rooms as there was no communal shower room and not all rooms had a shower in the en-suite.

Summary of findings

We found that the provider had employed a quality group manager who had been in post for five weeks. We found that they had recently introduced a number of audits to assess and monitor the quality of care. We were concerned that audits had failed to identify the issues that we found.

We were concerned that records relating to people's care were not always fully completed and were not maintained securely.

We found that although some improvements had been made to the way that the service provided pressure care there were still some concerns about how the service was ensuring that risks were appropriately assessed and managed.

We found two breaches of the Health and Social Care Act 2008 Regulations during this inspection. You can see the action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

There were sufficient staff on duty to meet people's needs.

Risks associated with people's care had been assessed. Control measures that had been identified to reduce risks associated to people's health and safety were not always in place.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People's care plans contained information about their life history and preferences. Relatives told us that people's needs were being met.

People's care needs were assessed but they had not always been updated following any changes to people's needs.

Requires improvement

Is the service well-led?
The service was not consistently well led.

Quality audits and systems had been introduced.

Systems and processes in place were failing to mitigate risks relating to people's health, safety and welfare. An accurate, complete and contemporaneous record for each service was not being kept.

Requires improvement

Broadoak Lodge

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Broadoak Lodge on 27 and 28 August 2015. This inspection was done to check whether the improvements we required the provider to make after our 18 March 2015 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, responsive and well led. This is because the service was not meeting some legal requirements.

The inspection was undertaken by three inspectors. During our inspection we spoke with the provider's quality group manager, the acting manager of the service, two senior staff members, six care assistants, a member of domestic staff, the cook and the kitchen assistant. We spoke with three people using the service, a visitor to the service and three relatives of people using the service. We also observed people receiving care. The majority of people who used the service were elderly and had limited mobility and dementia.

We looked at the care plans, risk assessments, and daily records relating to eight of the 20 people living at Broadoak Lodge. We also looked at the provider's audits that were in place.

Prior to our inspection we spoke with the local authority who had funding responsibility for some of the people living at the service. During our inspection we spoke with a district nurse who visited the service three times a week.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Broadoak Lodge on 18 March 2015 we found that there was a risk that people had not received the care that they needed to avoid the risks associated with pressure ulcers.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponded to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection 27 and 28 August 2015 we spoke with a district nurse who visited the service regularly. They advised us that they were happy with the pressure care being provided at the service. They told us how the service worked with the district nursing team and followed any advice and guidance that they provided. They went on to tell us how the staff at the service had provided care and support to help a person's pressure sore heal.

We found that where people were at risk of developing pressure ulcers, risk assessments had been carried out and control measures had been put in place to reduce the risks. We saw that these included pressure relieving mattresses, pressure relieving cushions, frequent positional changes and the administration of creams. We found that people had not developed any further pressures ulcers since our previous inspection. However, there was still a risk that people had not received the care that they needed. There were a number of gaps in the recording of positional changes and the administration of creams. We asked five staff members specifically about which people required positional changes. Their responses were inconsistent and people could not be sure that they were receiving the care and support that they needed.

We found that the one person had been identified at high risks of falls. The control measure that had been put in place was that staff would carry out checks on them every 30 minutes. We spoke with five staff members specifically about this person. Three staff members were aware that they required checking every 30 minutes but the other two staff did not. This was a concern as not all staff were aware of the control measures that had been identified to reduce the risks. Records that we looked at did not confirm that these checks were being carried out in line with the person's risk assessment. The provider could not be sure that control measures that had been put in place were being carried out. This person had fallen out of bed and sustained an injury to their head. The 30 minute checks had not been carried out for one and a half hours before they were found on the floor.

We saw that staff had written a statement about the above incident. However, this had not been further investigated by the manager to establish any causal factors or devise actions to prevent a further fall from occurring. However, there was evidence of communication with the district nurses about ordering a low bed for the person which was still on order at the time of our inspection. The persons care plan and risk assessment had not been updated following the fall.

There was a call bell system in place that enabled people to call for assistance if they needed to. There were two occasions within the last two months that this system had a fault and had to be turned off. On one occasion this was for a 48 hour period. This meant that people were unable to summon assistance if they needed it. This was a concern as although the manager explained that staff put in additional checks on people at the time, the provider could not be sure that these checks had happened. People's sensor mats would also not have worked as they used the same system. This meant that measures that had been put in place to ensure that people were kept safe did not work. We found that the person's fall detailed above had occurred during the period when the call system was not working. A risk assessment to address the issues relating to the call bell had not been carried out. The quality assurance manager did take immediate action to ensure that a risk assessment was put in place should this situation occur again.

We found that although some improvements had been made to the way that the service provided pressure care there were still some concerns about how the provider was ensuring that risks associated with people's care were being continually assessed, monitored and managed.

These matters are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

At our comprehensive inspection of Broadoak Lodge on 18 March 2015 we found that that there were continuing problems with people having to wait for staff to attend to them and of people not

Requires improvement

Is the service safe?

having their needs met.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponded to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection 27 and 28 August 2015 we found that the staffing levels were sufficient to meet people's needs.

People told us that there were times when they had to wait for staff to assist them but that there needs were attended to within a reasonable time. One person told us, "Staff can only support so many people at once especially when everyone eats and drinks at the same time." Another person told us, "The staff have a lot on."

Relative's comments about the staffing levels were positive. One relative told us, "There has always been sufficient staff at the times I visit and the times I visit vary." Another relative told us, "There seem to be enough staff. Occasionally there are no staff in the lounge but I've not seen anyone waiting for anything." However another relative went on to tell us, "'The staff are always busy, it would be nice to have more as they are always so busy. There are not enough staff all of the time, it varies."

Staff members told us that there were times when they were not sufficient staff on duty to enable them to meet people's needs. They told us that there were five staff members scheduled to be on duty between 7.30am and 9.30pm and two staff members on duty between 9.30pm and 7.30am. They explained that if these staffing levels were sustained then they were sufficient to meet people's needs. However they told us that there were a number of times during the daytime period when this had not been the case. We discussed this with the manager of the service who advised us that they did require five staff on duty during the day and this was their aim. The manager agreed that the staffing levels would be provided in line with the planned schedule and that staffing levels would continue to be reviewed as people's needs changed.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Broadoak Lodge on 18 March 2015 we found that care plans were not focused on people nor were they reflective of people's current needs. Care plans did not properly instruct staff about the action to take to meet individual's needs.

These matters were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 27 and 28 August 2015 we found that people's care plans contained details about their life history, employment and family. We found there was information available relating to people's preferences such as methods of bathing and the times they liked to get up or go to bed.

A relative told us, "[My relative] is pretty easily cared for, although she can be demanding with the dementia. [My relative's] not one for going to bed early, about 11pm, its fine [my relative] stays in the lounge to do what she wants." Another relative told us, "[My relative] is less particular with her routines now with the dementia," they went on to tell us, "She's clean, it's a nice room, no smell."

One person told us, "I had a shower this morning." They went on to tell us that they had to go into somebody else's room to have a shower though. Not all bedrooms had an en-suite shower facility some en-suites had low level baths. This meant that some people took showers in other people's bedrooms. There was one communal bathroom where there was a low level bath. We spoke with staff members who told us that all of the people at the service were unable to use the low level baths available and they told us that people's preferred to have showers. Staff told us that some people had to use the showers in other people's bedrooms. We found that eight bedrooms did not have a shower in them. Out of these six bedrooms were actually occupied. We discussed this with the quality group manager and manager at the service who told us that they speak with the provider about this situation and ensure that some action was taken to address it.

In three people's care plans we saw that there was reference to their eyesight and the importance of them having their prescribed glasses. We saw that spectacle care had been recorded as being completed but these people were not wearing their glasses. We observed one person looking for their glasses, however staff did not assist the person to find their glasses acknowledge this at all and the person sat back down. We spoke with staff about this person's glasses and they confirmed that the person did usually wear glasses but they thought they had been lost. During the second day of our inspection we saw this person's glasses had been found. This showed that staff had not been as attentive to that person's needs on the first day of our inspection.

We found that people's needs had been assessed and care plans were in place with the intention of people's needs being met. A relative told us, "On the whole [my relatives] needs are met, they look after her very well." Another relative told us, "Now with the Alzheimer's [my relative] doesn't have any particular preferences but I think her needs are met pretty well."

Although we received positive feedback from relatives about the service meeting people's needs we found that care plans and risk assessments had not always been updated following any changes. This was important to ensure that they remained reflective of people's current needs and were effective to continue to meet people's needs. For example, we found that one person's care plan stated that they were able to walk for short periods with two care staff but we saw them being assisted by just one staff member. Another person's care plan stated they required their food to be cut up. We saw this person being provided with a pureed meal and staff confirmed that this is what they had. There was a risk that people may receive inappropriate care as care plans had not been updated to reflect their current needs.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Broadoak Lodge on 18 March 2015 we found that the provider did not have an effective system to regularly assess and monitor the quality of service that people received. We also found that the provider could not assure themselves that people were

receiving the care that they needed in relation to pressure ulcer care.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponded to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us, "'We're not involved massively. I think we've had two or three surveys and two or three family meetings. We raise any concerns and they seem to take action. There had been some confusion with diabetic meds when [my relative] came home from hospital, but that was on the part of the hospital." Another relative told us, "'I've had a letter from the manager requesting a meeting about [my relatives] changing needs."

We found that the provider had employed a quality group manager who had been in post for five weeks. We found that they had recently introduced a number of audits to assess and monitor the quality of care. We saw that audits included things such as the appropriate completion of care records relating to continence support, food and fluid charts, repositioning charts and showering/bathing and a managers/senior daily visual audit.

We looked at the audits that had been completed. We were concerned that those audits had failed to identify that fluid charts were not being fully completed. There was a risk that they were not being effectively monitored to ensure that people were receiving adequate fluids to meet their needs. There was a failure to maintain an accurate, complete and contemporaneous fluid chart for these service users. Audits had also failed to identify that call bells and sensor mats could not be used at the same time and the risks associated with that.

There was no system in place to ensure that all staff were aware of measures that had been put in place to reduce risks. There was no system in place to ensure that these measures were being consistently carried out. We found that one person's care plan detailed that they should receive 30 minute checks to reduce risks associated with their care. It was not evident that these were always being carried out and this had not been identified. Records relating to this person's care were also inconsistent and that had not been identified through audits.

We found that records relating to the administration of creams had a number of gaps and had not been fully completed. This meant that the provider could not be assured that these creams had been applied as prescribed. There was not an accurate complete and contemporaneous record in respect of each service user and the administration of their prescribed creams. On the second day of our inspection we found that previous MAR charts had been shredded. This meant that an accurate record in respect of each service user had not been securely maintained.

We found that one person had bed rails in place. The bumpers were not correctly fixed to the rails. This could have posed an entrapment risk to the person. There was no risk assessment in place relating to the risks associated with the use of bed rails and bumpers. The manager confirmed that there were no regular checks carried out on the bed rails to ensure that they were safe to use. There was no system in place to identify that the bumpers were not correctly fixed or that these risks had not been assessed.

We had identified during our previous inspection that some radiators were painfully hot to touch and that this posed a risk to people that used the service. We found that a risk assessment in relation to these radiators had been carried out but control measures that had been put in place had failed to address the concern. We found three radiators that were burning hot to touch. Staff told us that these radiators were always this hot. Some service users were at risk of falls, had limited mobility and dementia. Therefore there was a risk that if service users fell against the radiators they would be unable to move away or recognise the danger of the heat. The process that had been put in place to assess and monitor people's safety had failed to identify this concern.

These matters are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Control measures that had been identified to mitigate risks associated with people's health and safety were not always in place. Risks had not been reassessed to ensure people's safety following any changes. Regulation 12 (a) &(b).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes in place were failing to assess, monitor and improve the quality of the service. Systems and processes in place were failing to mitigate risks relating to people's health, safety and welfare. An accurate, complete and contemporaneous record for each service was not being kept. Regulation 17 (1) (2) (a), (b) & (c).

The enforcement action we took:
We have issued a Warning Notice which we have asked the provider to comply with by 12 October 2015.