Broughton Lodge Care Home Limited

Broughton Lodge

Inspection report

88 Berrow Road
Burnham On Sea
Somerset
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Tel: 01278782133

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

Summary of findings

Overall summary

This inspection took place on 28 and 29 November 2017 and was unannounced. This was the first inspection since the provider changed in November 2016. This was a comprehensive inspection.

Broughton Lodge provides accommodation and personal care for up to 18 people. At the time of the inspection there were 17 people living in the home and one person staying for a period of respite. The service specialises in caring for older people including those living with dementia. Broughton Lodge is a detached property situated in the town of Burnham on Sea.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

Some information relating to staff's pre-employment checks was not available in staff personnel files.

There was not a crisis contingency plan in place in the event of an emergency and people not able to be accommodated in the home. The director confirmed this was in place following our inspection. Risks to people were assessed, however some of the assessments required additional information.

There were some gaps in staff training and staff required updates in some subjects. Where there were gaps in staff training, these had been identified and future training dates had been arranged for them.

People's rights were not fully protected because the home had not consistently acted in accordance with the Mental Capacity Act 2005 (MCA).

Medicines were stored safely and securely, the process for administering medicines was not in line with good practice, the director and registered manager amended this during our inspection.

Quality assurance systems were not always fully effective at identifying and addressing shortfalls in the service provided.

People felt safe at the home and with the staff who supported them. Staff were aware of the correct action to take if they suspected someone was being abused. There were adequate numbers of staff available to meet people's needs in a timely manner.

Systems were in place to reduce the risk of infections and we saw staff had access to personal protective equipment. Incidents and accidents did not occur often in the home, when they did they were recorded by staff. Accidents and incidents did not happen very often however when an incident had occurred, learning from it was shared with the staff team.

Staff monitored people's health and well-being and made sure they had access to other healthcare professionals according to their individual needs.

People commented positively about the food, people had access to a choice of food and received adequate nutrition and hydration.

Staff received regular one to one supervision and they commented positively about the support they received from the registered manager.

People were supported by staff who were kind and caring. Where people found it difficult to express themselves, staff showed patience and understanding. Staff treated people with respect and dignity.

The home was responsive to people's needs and people were able to make choices about their day to day routines. People had access to a range of organised and informal activities, people told us they would like to do more art and craft activities and cooking. The director told us they would look into arranging this.

People were able to follow their religious and spiritual beliefs because religious services were held at the home. People and their relatives contributed to the planning of their care. The registered manager was in the process of transferring all of the care plans over to a new format which was person centred.

People and their relatives were aware of the complaints procedure and felt confident to raise any concerns with the registered manager.

There was a person centred and open culture in the home. People, their relatives and the staff commented positively about the management of the home. There was a clear vision and staff were aware of this.

There were systems in place to ensure people, their relatives and the staff were engaged and involved in the home. The home worked in partnership with a range of external professionals.

We have made a recommendation about the service reviewing how they support people in line with the Mental Capacity Act 2005.

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

Some aspects of the service were not fully safe.

Recruitment information was missing from some of the staff's files.

People's medicines were stored safely and securely. Medicines records were accurate and up to date.

Risk's to people's safety was assessed, some of the assessments required more detailed information.

People were supported by staff who knew how to recognise and report abuse.

Systems were in place to minimise the risk of infection.

There were sufficient staff available to meet people's assessed care and support needs.

Lessons were learnt and improvements were made when things went wrong.

Is the service effective?

Requires Improvement

Some aspects of the service were not fully effective.

People were supported by some staff who had not received up to date training in some subjects.

People's rights were not fully protected because the principles of the Mental Capacity Act 2005 were not always being followed.

People were supported to have enough food and fluids.

People were supported by staff who felt supported in their role.

People's healthcare needs were supported and met. The home worked within and across other healthcare services to deliver effective care to people.

The premises met people's needs and they were able to access

different areas of the home freely.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People were supported in line with their preferences.

People were supported by staff that treated them with kindness, respect and compassion.

Is the service responsive?

Good

The service was responsive.

People were supported by staff that used person centred approaches to deliver the care and support they required.

People were supported by staff that recognised and responded to their changing needs.

People were supported to access the community and take part in activities within the home.

A complaints procedure was in place. People and their relatives told us they felt able to raise concerns with the staff and management.

People's choices and preferences around the care they wished to receive at the end of their life was discussed and recorded.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Some improvements were needed to the quality monitoring systems to ensure all shortfalls in the service were identified and responded to.

The registered manager and director promoted inclusion and encouraged an open working environment.

Staff supporting people received feedback and felt recognised for their work.

The home was led by a management team that was approachable and respected by the people, relatives and staff.

There were systems in place to ensure people and their relatives had an opportunity to provide feedback on the service and be involved in any changes.	

Broughton Lodge

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 28 and 29 November 2017 and was unannounced.

The inspection was completed by one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including statutory notifications (issues providers are legally required to notify us about) or other enquiries from and about the provider. We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We requested this information during our inspection. We also requested the views of service commissioners from the local council who also monitored the service provided by the home.

During the inspection we spoke with 11 people and three visitors including people's relatives and friends, about their views on the quality of the care and support being provided. We spoke with the registered manager, one of the directors and six members of staff including the cook and the cleaner. We also spoke with one visiting health professional.

We viewed the premises and observed care practices and interactions in communal areas. We observed lunch being served. We looked at a selection of records which related to individual care and the running of the home. These included four people's care records, medication administration records, four staff personnel files and records relating to the management of the service, including quality audits.

Requires Improvement

Is the service safe?

Our findings

Recruitment procedures were in place to ensure staff employed were suitable for their role. Staff had to attend a face to face interview and provide documents to confirm their identity. Staff also had a range of checks completed before they were allowed to support people, these included employment references and checks by the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people. However, one staff members' file did not include information relating to the outcome of their DBS check. The registered manager and the staff member reassured us this check had been completed and we saw the application for the DBS had been completed and sent. Following our inspection the director told us the DBS had not been located and they had applied for a new one to be processed. They also told us they had put a risk assessment in place for the staff member until they received the new DBS check.

We noted three staff members application forms included gaps in their employment history that had not been explored. Having unexplored gaps in employment could impact on a staff member's suitability to work with vulnerable adults. We discussed this with the registered manager and director who told us these staff members were employed prior to the new provider taking over the home in 2016. They also told us they would ensure all staff application forms would be reviewed and any gaps in employment explored. Following our inspection the director confirmed they had completed this.

There were risk assessments relating to the running of the service and people's individual care. They gave information about how risks were minimised to ensure people remained safe. Assessments covered areas where people or others could be at risk such as moving and handling, risk of falls, risks of malnutrition and risk of pressure ulceration. We found some of the risk assessments required additional information. For example, where people required support with equipment if they experienced a fall and were unable to get up, we found specific information relating to the equipment was not always detailed in the risk assessment. We discussed this with staff who were able to tell us about the equipment used. The provider told us they would ensure all of this information would be included in the risk assessments.

When incidents or accidents happened in the home staff recorded these on incident forms. Incident forms were reviewed by senior staff and information was passed onto the manager if required. Staff told us incidents and accidents did not regularly occur in the home and records confirmed this. The director told us they did not have a process for formally reviewing incident and accidents to identify any themes or trends. Following our inspection they confirmed this would be completed and they sent us a copy of an updated incident form that included an 'analysis' section.

Where an incident had occurred we saw lessons were learned and improvements were made, for example the security of the home had been improved following an incident. Information relating to this had been shared with the Care Quality Commission, the local authority, the person's next of kin and the staff team.

There was no current crisis contingency plan in place for the event of an emergency situation which could result in the stopping of the service. For example a utility failure, extreme weather conditions or widespread

staff sickness. We discussed this with the registered manager who told is they had good links with homes in the local area and in such a situation they would liaise with them. They also demonstrated they had emergency contact numbers for the utilities companies. The director told us they ensure a crisis contingency plan in place, following our inspection the director send us a copy of a crisis contingency plan they had created which covered the action they would take in the event of an emergency.

People had medicines prescribed by their GP to meet their health needs. We observed the medicines round, which was completed by a senior member of staff. Each person's medicines was dispensed into individual lidded pots at the same time and placed in a locked boxed. The staff member then carried the box to each person who required their medicines and administered them. Dispensing all of these medicines at the same time is not recognised as good practice, this is because it increases the likelihood of an error occurring and records not being up to date. We discussed this with the registered manager and provider who stopped this practice immediately and ensured each person had their medicines dispensed and administered individually.

During the medicines round the senior staff member wore a tabard stating they should not be disturbed, which ensured staff were aware they should not be interrupted. We observed the senior staff member ensuring people had swallowed their medicines by observing them from a distance to ensure the medicines were taken.

People told us they were happy with the way staff supported them with their medicines. One person told us, "The staff deal with that." People did not manage their own medicines; however we saw there were systems in place to support this if a person chose to do this.

Medicine Administration Records (MARs) were accurate and up to date. Medicines were supplied by a pharmacy on a monthly basis; a record was kept of all medicines received at the home and those returned to the pharmacy. Medicines were stored securely and safely. Suitable arrangements were in place for medicines, which needed additional security. We checked the stock of four medicines against the records and found they were accurate. Records confirmed medicines were checked by senior staff and the registered manager to ensure they were being managed safely. Some people were prescribed medicines to be taken 'as and when required', we found there were clear guidelines in place detailing how and when these should be given to ensure they were administered safely.

No covert medications were being administered at the time of our inspection and the service had not had any medication errors in the previous six months. We noted that the temperature of the medication storage room and medication fridge had been taken and recorded on a daily basis. This ensured that medicines were stored at the optimum temperature.

Staff received medicine administration training and had a competency check before they were able to give medicines to people. The registered manager and senior staff completed on-going competency checks on the staff to ensure they remained competent to administer medicines.
People told us they felt safe living at Broughton Lodge. One person told us, "I feel safe now, but not in the beginning until they got to know me." Some people chose not to share their views with us but all appeared very comfortable with staff.

Relatives also told us they had no concerns about the safety of their family members. One relative told us, "If I was worried about anything I would talk to staff and the manager but have not had any concerns." We saw people were offered the option to have a key to their bedroom to enable them to lock their door to secure their room and belongings if they wanted to.

Staff also felt people were safe living in the home. One staff member said, "Yes they are safe here." There were systems and processes in place to safeguard people from abuse. All staff spoken with were aware of indicators of abuse and knew how to report any concerns. Staff were confident that any concerns would be fully investigated to ensure that people were protected. They were also aware they could report concerns to other agencies outside of the organisation such as the Care Quality Commission. One staff member said, "I would report it to the manager and I am confident it would be followed up, I know I can go higher in the organisation or speak to CQC." The home had a policy which staff had read and there was information about safeguarding and whistleblowing available for staff. One staff member told us, "We have all had to read the whistleblowing policy and I would use it, but I have never seen anything like that here." This meant people were supported by staff who knew how recognise and report abuse.

People were supported by sufficient number of staff to keep them safe. People and relatives told us they were supported by enough staff to meet their needs. One relative told us, "Staffing is always ok."

Staff told us the staffing levels were safe at the home, they commented some days were busier than others depending on how people were "On the day." Staff confirmed if they were particularly busy the registered manager would help out. Comments from staff included, "Staffing levels are ok, we can have bad days but we all muck in and the manager will help out, it's manageable" and "Staffing levels are ok, there are enough staff and shifts are covered."
During our inspection we observed the there were enough staff available to respond to people's needs and call bells were answered promptly. We looked at the staff rotas and discussed staffing levels with the registered manager and director. They told us that staffing levels were based on people's needs. The director told us they did not use a specific tool to assess and review staffing levels. The registered manager told us staffing levels were reviewed on a day to day basis and the director confirmed if they needed more staffing due to a person's change in need, this would be provided.

There were a range of checks in place to ensure the environment and equipment in the home was safe. These included, a fire risk assessment, testing of the fire alarm system, personal emergency evacuation plans, water temperature checks and regular servicing and checks on equipment. The fire risk assessment stated fire drills should be carried out every three months. We found fire drills had not been carried out in line with the risk assessment; we saw this had been identified in the health and safety audit carried out in October 2017. We discussed this with the registered manager who told us they would arrange for a fire drill to be completed. Staff confirmed they received fire training and felt confident to evacuate the building if needed in the event of a fire.

There were systems in place to ensure people were protected from the risk of the spread of infection. Housekeeping staff were employed to clean the home and there were cleaning schedules in place for them to follow. All areas of the home were clean and free from any odours. Staff had access to personal protective equipment and we observed them using this appropriately during our inspection. Each person had an infection control risk assessment identifying any potential risks and control measures in place to prevent the risk of infection. The registered manager completed regular infection control audits to ensure safe practice was being followed.

Requires Improvement

Is the service effective?

Our findings

We reviewed the staff training records and found not all staff had received refresher training in some subjects. For example, 10 staff had not received refresher training for safeguarding; the director confirmed these dates would be booked for January 2017. Five staff had not received training in the Deprivation of Liberty Safeguards, one of these staff members was on maternity leave another two staff had not received infection control training. We discussed this with the director who told us following the inspection they had arranged to ensure all staff received up to date training in these subjects.

All staff had received up to date training in moving and handling people and fire safety. There were also plans to ensure all staff received training in subjects specific to people's needs such as dementia, nutrition and wellbeing. The director also confirmed they were liaising with their training provider to arrange training in diabetes, equality and diversity, dignity and respect and managing behaviour that challenges for all staff.

We reviewed how people were supported in line with The Mental Capacity Act 2005 (MCA). The 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.

Within care records we saw that capacity assessments for people had been completed where they lacked capacity to make some decisions. For example, receiving care at the home and for one person being supported to reduce their anxiety about living in the home. However, we found some areas where capacity assessments had not been completed where required. For example, where three people had equipment in their room to monitor when they got up from their bed and they did not have the capacity to understand this was in place, relevant capacity assessments and best interest decisions had not been made. We discussed this with the registered manager and provider who following our inspection confirmed these had been completed. They also demonstrated they had put in place consent forms for where people had the capacity to consent to the monitors being in their room.

We recommend that the service revisits guidance relating to the Mental Capacity Act 2005 in relation to supporting people to make decisions.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care services is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for 10 people who required DoLS had been completed, one of which had been authorised with no conditions and the other nine were pending assessment by the local authority. This meant the provider was meeting their legal responsibility in relation to the DoLS.

People told us staff had the right skills and knowledge to support them. Staff told us they received an

induction when they commenced employment. They told us the induction prepared them for the role and they felt supported during this process. One staff member told us, "I did a lot of shadowing, getting to know people and reading, I felt ready and supported."

We looked at the providers induction pack and this related to the preceding Common Induction Standards rather than the current Care Certificate. The Care Certificate is an identified set of induction standards that health and social care workers should adhere to when performing their roles. We discussed this with the registered manager who told us there were plans for the induction to link with the Care Certificate. They also confirmed all of their staff held national vocational qualifications which covered the outcomes identified in the Care Certificate.

Staff described training they received as, "Very good" and "Enough to do the job." One staff member commented on how the registered manager was supportive and encouraged staff to obtain recognised qualification. They also said if a staff member wanted to attend a training session that was not part of the scheduled training the manager would support this.

Staff told us they had formal supervision (a one to one meeting with their line manager to discuss their work) to support them in their professional development regularly. They told us supervision gave them an opportunity to discuss their performance and identify any further training or support they required. Records confirmed this. One staff member told us, "Supervisions are regular, we can raise any concerns and they listen." Another commented, "We get regular one to one supervisions where we get constructive feedback." This meant people were supported by staff who were in turn supported by their managers.

People's needs and choices were assessed and planned for. Each person had a pre-assessment that was completed before they moved to Broughton Lodge. This was used to create a plan of care and included details of people's needs and preferences. People told us they discussed with the staff their choices and preferences on an on-going basis.

People commented positively about the food provided. People described the food as, "Good." One person told us, "The food is generally very good. Some things I don't like but there is always enough, it's not a major problem." People also confirmed staff were aware of their food likes and dislikes. One relative told us, "The food is always lovely."

People were supported to maintain a healthy diet and people who were at risk of malnutrition were assessed and monitored by staff where required. We observed people had access to drinks in the communal areas and in their bedrooms. We observed staff encouraging people to have a choice of drinks throughout the inspection to ensure they remained sufficiently hydrated. Staff also offered people choices of sandwich fillers and ice cream flavours.

People told us they could choose where they ate their meals and some of them told us they regularly chose to have their breakfast in their bedrooms. We observed the lunchtime meal which was a social event with people chatting to each other and staff. Staff ensured there were condiments available on the tables for people to use if they chose. Where required people had adapted cutlery to enable them to eat independently. Where one person started to become anxious, staff immediately responded and provided support in a calm way which prevented the situation from escalating.

There was a four weekly rolling menu with two main meal options available each day. We spoke with the cook who told us if someone wanted something different on the day they would offer different choices. Feedback on the meals provided was sought at residents meetings and this information was passed over to

the cook following the meeting for them to act upon. The cook demonstrated knowledge of people's likes and dislikes and dietary needs and they had a list of these available in the kitchen.
People's health care was supported by staff and by other health professionals. One person told us, "The GP comes every Friday, if I want to see them I just ask and they come to see me." Another person commented that staff had supported them to attend a recent hospital appointment.

People's care records showed referrals had been made to appropriate health professionals when required. These included the chiropodist, optician, the district nurse and the mental health team. When a person had not been well, we saw that the relevant healthcare professional had been contacted to review their condition. This meant people's healthcare needs were being met and they received on-going healthcare support. A health professional commented on how staff communicated well, they thought the staff team were aware of people's needs and that they followed advice and guidance.

People were able to move around the home freely and request staff support as and when. Parts of the home were equipped with suitable equipment such as hand rails and assisted bathing facilities to promote people's independence where possible. Bathrooms were clearly signed and the doors were painted red to enable people to orient themselves to the bathrooms. The garden had recently been refurbished with raised beds to enable people to view the plants without bending down to the floor. The registered manager and director told us they had a plan to refurbish areas of the home including the bedrooms and communal areas. We saw this had started to be implemented.

Good

Is the service caring?

Our findings

People were supported by caring staff who treated them with kindness, we observed staff being respectful in their interactions with people. The atmosphere in the home was calm and homely.

People and their relatives commented positively about the staff working at Broughton Lodge. One person told us, "They are good here, not at all bossy." Another commented, "They cheer me up." Comments from relatives included, "The staff are very caring."

People told us staff knew them well. We observed when people became anxious staff responded quickly and in a caring way. We observed people were given emotional support when required.

Staff recognised people's body language and offered support in a discreet way. For example, one person was starting to move around in their chair during lunch, staff immediately went over to the person and discreetly offered them support to use the toilet. Staff knew people well and were able to tell us about what was important to people, their likes, dislikes, personal histories and families.

Staff spoke positively about the people and they described how they had empathy for the people they supported. One staff member told us how they supported a person who could be reluctant to accept personal care. They told us, "[Name] can be reluctant to have a bath, we offer encouragement and try to make them feel relaxed. People understandably can be embarrassed and I always think about how I would want to be treated." They went on to describe how they made the bath like a 'spa' with lots of bubbles and they told us this had been a success.

We saw feedback cards from relatives to the registered manager and staff team giving positive comments about the staff. Comments included, "Thank you whole heartedly for the care and compassion you and your team showed my late father" and "Staff were warm and caring which instantly reassured mum."

People were able to see visitors when they wished. There were relatives and friends visiting people in the home during the inspection. Relatives told us that they are always made to feel welcome. We saw a comment from a relative in a thank you card which stated, "We were instantly made to feel welcome, it was apparent from the outset that staff showed a genuine interest in mum." A health professional also commented the staff were welcoming.

People were supported to make choices about how, where and when they received support. One person told us, "I tell staff what I need when they help me." People made choices about when they got up and went to bed, meals, where they wanted to spend their time and the activities they wanted to participate in. Visiting relatives told us they were kept informed about any changes and were involved in decisions where people were unable to fully express their views.

Care plans were planned around people's daily choices. For example, one person's personal care routine stated 'depends on daily mood', which meant the person could make a choice each day about the support

they wanted. Another person's care records noted they had chosen to get up 4am, staff had respected this decision and offered them a cup of tea and some breakfast. Staff described how they promoted choice and decision making and they were aware of the importance of promoting people's independence. One staff member said, "We always ask people what support they would like and encourage them to do what they can for themselves."

People told staff were respectful and knocked on their doors before entering their bedrooms. One person told us, "They invariably knock on my door before coming into my room." A relative told us the staff, "Treat people with dignity." We observed staff knocking on people's doors before entering them. We saw in one person's room personal information relating to the creams applied to their skin was present on their medicines cabinet. We asked staff if the person was happy for this information to be on display in their bedroom and they thought they were, however they were not 100 per cent sure. We discussed this with the registered manager who told us they would speak to the person about this and arrange for a folder to be placed in their room to hold this personal information. Following our inspection the director showed us a form they had created to demonstrate if people agreed to have this information available in their room on display.

People had en suite toilet facilities in their bedrooms, some of these were separated by a curtain, which could impact on people's privacy. We saw these were being replaced with doors and the registered manager confirmed there were three left to replace. Staff were aware of the importance of confidentiality and we saw people's records were stored securely.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs and wishes. Each person had a care plan that was personal to them. The registered manager told us they were in the process of transferring the care plans on to a new format and this had been their recent priority. They told us they had three left to transfer and the director confirmed they had planned to complete this by the end of 2017.

The registered manager explained how the new format was person centred and focused on the person. We saw the care plans were centred around the person and they reflected how people wanted to be supported, what they could do for themselves and the support they required from staff. The care plans focused on people's individual needs and preferences and they included information relating to people's preferred routines during the day and night, cultural needs, preferred activities and their life histories.

We saw some sections in some of the care plans still needed to be completed. For example, the care plans had a 'this is me' section which hadn't been fully completed for some people. The registered manager told us they had invited people's relatives in to a meeting to enable them to discuss this information so that it could be added to the plans. The director explained they were completing the transfer in two phases, the first one to transfer the information they had and the second to review the quality and content.

People and their relatives contributed to the planning of their care, we saw people had signed their care plans to demonstrate their agreement. People were aware of their care plans, one person told us, "There are records in the office, but the staff know me well and don't need to look at them." Staff described how they were supporting one person who has recently moved into the home and how the person had initially been reluctant to accept staff support. They described how they worked with the person to gain their trust and how the person was making good progress. A health professional commented on how the staff team had supported one person to improve their mobility.

We discussed with the registered manager how they promoted communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Where people had sensory impairments such as hearing loss we saw this was documented in their care plan and details of how staff should support them with this. There was a hearing loop available in the lounge to support people who had hearing loss. The registered manager showed us resources they had in picture form relating to meals, drinks and food which they said they used if people were unable to verbally communicate their choices. The also told us they had large print novels in the home available for people to use if they had any sight difficulties.

People's wishes regarding what treatment they wished to receive was recorded because the staff worked with people's GP's. This made sure there were plans in place to state under what circumstances they wished to be admitted to hospital and if they wished to be resuscitated. People's preferences about the care and treatment they wished to receive at the end of their lives was documented in their care plans and relatives were involved in providing this information where relevant. This helped to make sure people received care in

accordance with their wishes.

People were supported to stay in touch with friends and family to promote their emotional well-being. One person's family members visited them every week to have lunch with them. People were able to follow their religious and spiritual beliefs because religious services were held at the home. The home also arranged for people to attend a service at a local Baptist church each month.

There were a range of activities on offer in the home, these included external companies coming into the home for 'pat a pet' sessions and music and dance. Staff also told us they carried out activities within the home such as quizzes, arts and crafts and pamper sessions. Whilst people told us they enjoyed the activities on offer some of them told us they would like to do more arts and crafts and cooking. We discussed this with the director who told us they would look into this. We noted people had recently been involved in creating their own festive Christmas decorations. Parties were held in the home to celebrate season and events such as the summer and Easter. We saw a picture in the quarterly newsletter of the Easter party where hatching chicks were brought in for people to see and the Easter bonnet making was noted as an activity that was enjoyed by people.

On the first day of the inspection the arranged activity was cancelled due to the external event organiser cancelling. We observed a staff member starting to engage people in a quiz in the afternoon but this had to be cut short due to the staff member needing to support a person with their personal care. The other staff member on duty was supporting a person because they required some one to one support at the same time. Staff told us they tried hard to ensure activities were carried out; however the cancelling of the external activity provider had been unforeseen. One staff member told us, "We can do activities unless like today where there is an incident where someone needed one to one support."

On the first day of the inspection a staff member popped out to do some grocery shopping and arranged for a person to go with them so they could also do some shopping. On the second day of our inspection people were being supported to attend an event arranged by the local Baptist church. People spoke positively about an ice cream van that had visited the home in the summer, one person said it, "Reminded them of going to the seaside." Two people told us they enjoyed reading and they told us there were a lot of books available for them to read, we observed a staff member talking to one person about the book they were reading. Where people chose to have daily newspapers this was clearly documented in their care plans and we saw these were delivered on the days of the inspection.

People and their relatives said they would feel comfortable raising a concern if they needed to. One person told us, "I would talk to the manager if I was worried about anything." Another commented, "The manager comes around and asks if you are happy."

There had been two formal complaints received by the service in the past year. Records demonstrated complaints were responded to and action was taken to rectify issues where concerns were raised. For example, where a relative had raised a concern about an item of clothing being damaged whilst it had been washed, the registered manager was arranging for a refund of the cost of the clothing.

Requires Improvement

Is the service well-led?

Our findings

There were a range of audit systems in place; however they were not always fully effective in identifying shortfalls in the service and ensuring improvements were made. For example, they had not identified the concerns relating to shortfalls in the Mental Capacity Act 2005 (MCA), the lack of a crisis contingency plan, staff files not containing exploration of any gaps in employment and information relating to the disclosure barring service. Whilst the registered manager and director responded promptly to the shortfalls we identified and put actions in place immediately to remedy them during our inspection, the current governance systems in place had not identified them.

We discussed this with the director and registered manager who told us they had an overarching action plan in place since taking over as the provider in November 2016. They stated there had been a lot of work that needed to be completed and their initial priority had been to focus on the care plans, the registered manager confirmed they had been focusing on the Deprivation of Liberty Safeguards applications and MCA assessments. They had also met with people and their families and implemented regular relatives and residents meetings to obtain their feedback. We reviewed their action plan and this confirmed the action they had taken to make improvements to the service.

The registered manager completed a range of audits on the home which included, medicines, care plans, infection control, health and safety and dignity in care. Where shortfalls had been identified during these audits were saw there were action plans in place to address them. The director also completed a monthly owner review of the service. We reviewed records of these meetings which covered areas such as medicines, staffing, health and safety, home improvements and complaints.
The registered manager had worked in the home for a number of years and had applied to become the registered manager in 2016. People and their relatives spoke highly of the registered manager and confirmed they maintained a regular presence in the home. The registered manager confirmed they were well supported by the director who contacted them every week to discuss any concerns or issues. They also said the director was available on the telephone for additional support at any time.

The registered manager had knowledge of the people who lived at the home and the staff who supported them. They spent time in all areas of the home which enabled them to constantly monitor standards. People were very relaxed and comfortable with them and described the registered manager as approachable. One relative told us how things had improved in the home since the new provider had taken over in 2016, commenting, "You can make suggestions and things happen."
All staff spoken with liked and respected the registered manager. One staff member said, "[Name of registered manager] is a leader, she joins in and is there for us." Another commented, "She is fair and approachable and will always follow up on any concerns."

The registered manager told us they promoted an open door policy for staff to approach them. Staff confirmed this. One staff member told us, "[Name of registered manager] always stresses we should talk to her, she is approachable and has an open door policy." Another commented,"[Name of registered managers] door is always open, she is fine as a manager and [name of senior] is good too."

People told us there was a nice atmosphere in the home, one person told us, "Staff seem to get on well here which makes a difference to the atmosphere." Staff commented positively about the team culture and about working at Broughton Lodge. Comments included; "We all work together so that things can run smoothly and we have good communication within the team", "We work well together" and "I love my job." This meant people were supported by staff who were motivated and positive about their work.

The provider sought the views of people and their relatives by satisfaction surveys and regular residents and relatives meetings. Meeting minute's demonstrated people were able to give feedback on areas such as the menu's, bathing routines, respect, dignity and privacy, activities and any upcoming changes to the home. Where people gave feedback we saw action was taken, for example, during our inspection people had expressed they would like ice cream for pudding this was offered straight away. Staff, people and visitors also had the opportunity to feedback through the use of a suggestions box. The registered manager said that they encouraged and promoted feedback and new ideas. Newsletters were distributed quarterly which gave people and their relatives information about new staff members employed, refurbishment plans, entertainment and parties that had been arranged.

Staff meetings were held which were used to address any issues and communicate messages to staff. One staff member told us, "We go through everything in staff meetings, we can say what we like and I think we are listened to." Another commented, "We have meetings every couple of months and look at ways we can improve. You can put your views across and they do listen." Meeting minutes reviewed demonstrated where incidents had occurred in the home these were reviewed and discussed and any learning was shared with the team.

The key aims of the service were described in the home's statement of purpose. One of the service's key aims was "Our emphasis is to make the Home 'your Home'." Staff told us the visions of the service was; "To look after the residents, make sure they are safe and to make it a home from home" and, "We want to create a friendly atmosphere where the residents are comfortable and happy in their home." This meant staff were aware of and shared the vision for the service.

The registered manager had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal responsibilities. Where concerns had been raised with them they had sought advice and shared information with the CQC and the commissioners of the service.