GCH (Home Counties) Limited

Broxbourne Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Broxbourne Nursing Home is a residential care home providing nursing care to up to 77 people. The service provides support to elderly people some of whom may live with dementia. At the time of our inspection there were 33 people using the service.

Broxbourne Nursing Home is a purpose-built, nursing home. The environment is adapted to meet the needs of people who live with a physical or sensory disability over two floors. Bedrooms and communal areas are spacious and comfortable for people to spend their time.

People's experience of using this service and what we found
People told us they felt safe living in the home. However, we found that safeguarding concerns were not always investigated or reported to the local authority. Incidents and accidents were not thoroughly analysed and further measures to mitigate risk of re-occurrence not considered.

People were not always admitted into the home safely. Pre-admission assessments were not thoroughly completed to ensure people's needs could be met safely. Care plans were incomplete and lacked detail and guidance for staff to know how to keep people safe and in good health.

Checks were not in place to assess staff's understanding following the on-line training they completed. Practical training sessions were not provided for training such as moving and handling people safely. This meant staff had not had the opportunity to practice how to safely support people with equipment such as a hoist. Staff had not received regular one to one support to discuss their performance and review their work practices.

People were not always supported in a kind way. Whilst staff were kind and compassionate towards people, they had insufficient details and guidance in place to enable them to support people in a kind way. The care and support people received was not person centred. People's likes and dislikes were not considered when their care and support was planned and delivered. People were bored due to the lack of social activities provision.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The registered manager failed to provide effective leadership and support to enable staff to understand how to provide people with quality care. They failed to maintain an effective oversight of the service to ensure the care and support people received was safe. The registered manager lacked understanding of how to effectively use the provider's governance systems. As a result, people were put at risk of, or sustained harm. The provider had failed to address consistently poor practice in relation to the management and oversight

of the home.

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

Rating at last inspection
This service was registered with us on 09 June 2022 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, risk management and leadership. 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 found that people were at risk of harm from these concerns. You can see what action we have asked the provider to take at the end of this full report.

The provider took immediate action to ensure people were safe. They stopped new admissions into the home, increased staffing and developed a service improvement plan to address areas of concern.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding, safe care and treatment, person centred care, staffing, failure to notify CQC of notifiable incidents, failure to be open and hones about accidents and incidents, and leadership at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Inadequate**

Broxbourne Nursing Home

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 Health and Social Care Act 2008.

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 has been carried out by two inspectors.

Service and service type
Broxbourne Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Broxbourne Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since they opened. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and three relatives. We spoke with seven members of staff including one chef, clinical deputy manager and quality improvement manager. We also spoke with the registered manager, the provider's regional manager and a quality manager.

We reviewed a range of records, this included seven people's care records. We looked at medicines' records and several staff files in relation to recruitment. A variety of records relating to the management of the service and fire safety were also reviewed, including incident records, complaints, compliments, quality assurance processes including audits and policies and procedures. We spoke with two visiting health professionals.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We spoke to the Local Authority Commissioning team, the provider and continued to request information needed from the service to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Staff told us they had safeguarding training and they reported their concerns to nursing staff and management in the home. They also said they recorded all incidents, unexplained bruises or any concerns they had about people. The registered manager had failed to recognise when to report safeguarding concerns to the local authority safeguarding team and had failed to notify CQC. This included unwitnessed injury and bruising, and frequent incidents between people some of which resulted in harm.
- Shifts were led by registered nurses, however the majority of the nurses working in the home were supplied by an employment agency. Although most were consistently used, these nursing staff did not have the required training to support people living with dementia who may require support when anxious or distressed. There were a high number of incidents between people where there was a risk of, or people were, harmed. These did not prompt the registered manager to consider further training for staff in positive behaviour support, to look at trends and patterns and try to identify triggers to such incidents. One relative told us, "I feel [person] is safe except for when [name of a person] is around. The other day, they turned against staff but that can happen to anyone."
- The registered manager and provider were unable to show us how they learned from safeguarding concerns. Many adverse incidents were not thoroughly investigated to ensure action was taken to remedy the situation, protect people, prevent reoccurrence and make sure lessons were learned and improvements made as a result.
- When adverse incidents did occur, this did not trigger the registered manager and senior staff to review the relevant risk assessments thoroughly and consider if the existing measures in place were still effective or if further measures were needed. This meant the risks remained in place for some of the people living in the service.

Failure to ensure safeguarding concerns were reviewed, investigated and reported appropriately left people at risk of harm. The culture operated by the registered manager did not ensure lessons were learned to minimise the risks of recurrence. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives told us they felt the care and support people received was safe. One person said, "I am safe. Staff explain to me what is happening and there are staff around." A relative said, "[Person] could not return home from hospital so here is safe. Staff are around to help if needed."
- The provider responded immediately to this concern after the first day of the inspection. They started to review and report the adverse incidents that had not been reported to the local authority and reviewed the risks relating to these. They also increased their monitoring of the service to ensure they responded promptly to any concerns raised by staff.

Assessing risk, safety monitoring and management

● Risks to people's health and well-being were not always managed well. Risk assessments were in place to assess the level of risk for areas like skin integrity, falls or weight loss. However, care plans were not always in place to detail how the risks were mitigated for people. For example, a person had been assessed as very high risk of falls. Their mobility care plan detailed they were at risk of falls but had no details that the risk was high and how were staff to support them.

● Some people's care records indicated they had diabetes, and this condition was controlled by their diet. We observed food served at lunch time and staff gave the same meal and dessert to people with diabetes as others. The chef told us they had information about people with diabetes, but they had no information about a recommended diet for these people. However, we found that not every person who had diabetes had been added to the nutritional overview shared with the chef.

● A visiting health professional told us, they would expect a well-developed nutrition care plan for people with diet-controlled diabetes and staff to promote the recommended types of food and drinks. We found two examples where nutritional care plans made no reference to diabetic diet people should have been offered. This put people at increased the risk of them needing further treatment for diabetes and their health deteriorating.

● The provider had air mattresses in place for every person admitted to the home. This was to mitigate the risk of people developing pressure ulcers. However, there was not detail in care records for staff to know the correct settings on these mattresses. In one occasion staff did not follow the specialist tissue viability nurse (TVN) advice on how to manage a person's wounds. They recommended daily dressing changes for one wound and alternate day for the second wound. Staff were changing the dressings every two to three days. The TVN also recommended the use of special boots to protect the person's heels. These were not in use at the time of our visit. The nursing staff told us they were asking for a GP visit for the person as they suspected they were developing another wound on their heel. This meant there was a risk that the person developed another wound due to staff failing to follow the TVN recommendations.

● People who were assessed as needing regular repositioning had not been supported with this need. Repositioning charts had gaps in recording for long periods or staff recorded that people were left in the same position. For example, one person had been assessed needing repositioning every 2 hours. Their repositioning chart for 02 November 2022 had no recordings from 6pm to 2am.

● Risk assessments were not in place for people living with dementia to guide staff to support them to express their emotions safely. Although some people frequently expressed themselves in ways that could frighten, or put others at risk of harm, staff had little guidance or experience to respond to this positively. Incidents were not reviewed and linked to a review of the risks and 2 people had experienced harm or had caused harm to others.

This was a breach of Regulation 12, safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider took immediate actions to start reviewing people's care plans, risk assessments and deployed additional resources to help ensure people's needs were met safely.

Staffing and recruitment

● People told us they thought there were enough staff. However, some relatives told us at times they felt the need for more staff. One relative said, "They could do with more staff but that's the way it is." The relative told us they knew there was a shortage of staff working in care homes, so they didn't want to complain or put more pressure on the registered manager by raising concerns about staffing.

● Staff told us they at times felt there was a need for more staff to allow them to spend more time with people. One staff member said, "I think we need more staff, but the managers are saying we have enough.

It's not about people not being safe but staff need to spend more time with people."
● We were not confident that the dependency tool used by the provider to help approximate staffing required to meet people's needs safely was correctly completed. We found examples where risk assessments or the care plans for some people were not always reflective of people's needs, therefore the dependency based on these records would not be accurate.
● The registered manager was unable to demonstrate how the staffing levels were kept under review to ensure that staffing levels were appropriately managed to reduce impact on people and to accommodate people's choices, such as getting up early in the morning.
● Following the inspection, the provider increased care staffing levels on the day shift. After our second visit to the service, we were informed by a visiting health professional that a person had attempted to cause harm to themselves. We discussed this with the provider, who agreed to add an additional staff member to the night rota to support people's mental health needs.
● Agency staff were regularly used for both care and nursing positions. However, both care and nursing staff did not have the specific skills needed to support those people living with dementia. The records for agency staff used were not maintained so the provider could not assure themselves staff were suitably skilled. The registered manager failed to ensure that seven agency staff who had worked in the home provided appropriate records about their training and legality to work in the home. This meant effective checks of temporary staff were not carried out before they started to support people in the service.

This was a breach of Regulation 18, staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Permanent staff were recruited in a safe manner, including obtaining Disclosure and Barring Service (DBS) checks which provide information, including details about convictions and cautions held on the Police National Computer. Where staff were employed from overseas the appropriate Home Office documentation and evidence of identity had been sought. All this information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines for some people were used to manage behaviours and anxiety. Nine people were prescribed medicines classified as anti-psychotics. Antipsychotics should only be used as a last resort to treat the psychological symptoms of dementia. The registered manager could not demonstrate to us where they had supported people positively with good dementia care and support, as opposed to using medicines to manage the symptoms. We shared this information with a visiting mental health professional who was not aware of the number of people prescribed these. They told us they would begin to review these people as a matter of priority.
● People were receiving their medicines as prescribed. People's care plans and protocols contained sufficient information to support staff to administer 'when required' medicines (PRN).
● Systems were in place to help ensure medicines were managed safely, to detect errors and take prompt action if any errors were found.
● Staff had received training to ensure they administered medicines safely and completed medicine records correctly.

We recommend the provider ensures all staff are sufficiently trained to positively support people's psychological needs and have plans in place to reduce the reliance upon prescribed medicines.

Preventing and controlling infection
● We were not assured that the provider was preventing people and visitors from catching and spreading

infections. On both days of the inspection we observed some staff not wearing their masks correctly. In some instances, staff removed their masks when talking to us and they were wearing their masks under their nose.

- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- 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 responding effectively to risks and signs of infection.
- 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 that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The provider was open to visiting and with people's consent they were able to have visitors in their home.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Pre-admission assessments were not completed thoroughly before people moved in the home and did not identify all the needs for some people. This meant that care plans and risk assessments were not then developed for all areas where support was needed. This put people at risk of not receiving the support they needed. For example, one person's needs could not be met safely at the service, they had to have one to one support until they were re-admitted to hospital. Another person missed important hospital appointments due to their condition not being recorded in their care notes.
- The registered manager did not ensure people's NHS-funded nursing care was in place when they moved into the home. The NHS pays for the nursing care component of nursing home fees because some people require this level of clinical care. At the time of the inspection people were being assessed if they needed nursing care. However, if this was not approved, they would need to move from Broxbourne Nursing Home or move to a privately funded bed within the home. Moving between services could cause people stress and anxiety and often a move can affect people's health. Following the inspection, we received information that at least 2 people were not eligible for this funding, with a further 11 awaiting an outcome.
- Some people living in Broxbourne Nursing Home were living with various stages of dementia from early onset to more advanced stages. Care plans were not person-centred, reflective of best practice or evidence-based to ensure effective outcomes were achieved. People were placed at risk of harm because risk assessments and care records did not instruct staff how to monitor and support their needs.

This was a breach of Regulation 9, person -centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff told us they were completing their on-line training when they commenced employment. They told us there was a requirement for them to complete several training subjects considered needed by the provider. One staff member told us, "I joined in April and I have just finished with all my training, but I will have to repeat some so training is never ending." Some staff we spoke to had difficulty remembering what training subjects they completed, however they told us it was not practical training only theory.
- Clinical staff were not provided with an induction or assessment of their competency prior to working in the service. They had not been provided with a framework of clinical support or supervision. Clinical supervision enables staff to explore their own personal and emotional reactions to their work, reflect on and challenge their own practices and engage in professional development, identify developmental needs and support revalidation.

● Care staff had not received supervision regularly with their line manager. Training was provided via an e-learning platform. There was no system operated by the registered manager to assess the quality of training staff received to ensure they had understood the content. The registered manager did not test staff skills, knowledge and competence to support people safely.
● Where training had been provided, this did not meet all the needs of people living in the service. Broxbourne Nursing Home is a newly commissioned home, opening in June 2022. The provider and registered manager had not ensured sufficient training in key areas was in place. For example, with advanced training for dementia, supporting people positively or the use of the electronic care planning system.
● Nursing staff who led the individual units had not been provided with essential training to ensure they had the skills and knowledge to support the staff they were responsible for. Nursing staff, although experienced with general nursing, did not have experience of supporting people living with dementia or associated needs. Only one permanent nurse was employed by Broxbourne Nursing Home. However, they had only recently completed their training to validate them as a nurse and had received no additional support or training for their role.

Staff were not supported to develop their knowledge or reflect on their practice. Staff did not all have the appropriate knowledge, skills, or training to provide safe and effective care. This was a further breach of Regulation 18, staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff told us it was important to listen to people's choices and involve people in their care. One staff member said, "We always give choices to people. It's important not to take their choice away."
● One staff member told us about a person who at times was waving their hands when staff supported them in bed. This put the person and staff at risk of being hurt. To ensure the person was safe on occasions three staff supported them, one holding hands gently and talking with the person whilst the other staff members carried out the task needed. There was no MCA, best interest or DoLS application made for this practice which could be considered restrictive
● Mental capacity assessments were poorly completed, lacked sufficient details, and for some people were not completed when required. For example, care records noted a person lacked capacity and had bed rails in place. No MCA had been completed or best interest decision recorded to evidence why it was in this person's best interest to have bedrails on when in bed.
● Some people's relatives had declared they held a lasting power of attorney [LPA]. An LPA covers decisions about financial affairs or health and care. It comes into effect when people lose the mental capacity to make certain decisions and provide consent to the care they receive. We found that evidence of the LPA had not

always been sought, but consent had been obtained from these relatives in the absence of these authorisations.
● We found several examples where consent arrangements were not in place that staff had shared personal information with people's relatives, who had then made decisions on their behalf. Staff had not considered whether it was appropriate to share this information, or whether people could make their own decisions as opposed to relatives making those.

This was a breach of Regulation 11, need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People had mixed views about the food and drinks provided to them. One person said, "I don't really like the food here." A relative said, "The puddings are not great, sponge pudding every day. It's not hard to offer other alternatives like yoghurts."
● Some people were identified at risk or they were losing weight. The chef told us they prepared milkshakes and other nutritious meals for people to help them keep healthy. However, we found that important information about people's diet had not been communicated to the chef. For example, if a person required a diabetic diet.
● People's food likes and dislikes were recorded in some cases, but staff had not always effectively used this information to promote good food and fluid intake by offering people what they liked.
● Tables were nicely laid for people to enjoy their meals in a social environment. However, there was loud music playing which made it difficult for any conversation during meals times. Some people commented on the food being hot and nice, but others told us they were not liking the food.

Adapting service, design, decoration to meet people's needs
● The environment was newly built, well maintained and fully accessible. Ground floor rooms had access to outside areas, with bright spacious communal areas including a cinema, hairdressers and coffee shop for people and visitors to use. However, most of the people living in the service had a diagnosis of dementia. The environment did not support people positively to live within the home and find their way around. For example, corridors were featureless, lacking items of reminiscence, appropriate signage, or clearly defined doors to support people to find their own bedrooms.
● Equipment and facilities were clean and fit for use. People who required specialist equipment to keep them safe had these in place, such as bed rails, pressure relieving equipment or sensor mats.

We recommend the provider reviews national guidance to ensure the environment can make a fundamental difference to the lives of people with dementia.

● During the inspection the provider brought the organisations dementia lead into the service to offer support and guidance to staff and to support environmental adaptations.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Some people required external health professionals' input to ensure their health remained stable or improved. We found on some occasions there was a delay in requesting this input. For example, a person had been admitted to the home with pressure ulcers. Only when their relatives raised concerns about the way staff supported the person did staff involved a tissue viability nurse in their care.
● It is recommended best practice for people who are prescribed antipsychotic medicines to have involvement from a mental health specialist with the view of reducing these medicines and implementing

alternate therapies like positive behaviour support. At the time of the inspection a mental health specialist visited three people and told us they were not aware that an additional six people had been administered these. They told us they would organise for people to be reviewed by a mental health specialist.

● Staff were not always clear about referral pathways to external health professionals. This led to people who needed a referral for crisis intervention to experience delays in getting the support they needed.

● On the day of our visit a dietician reviewed people's nutritional needs and they told us there were areas where they suggested improvement in the support people received.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- The leadership in the home failed to ensure that the systems and processes in place centred around people. Staff showed kindness towards people, however the lack of guidance for staff put people at risk of not receiving care and support in a kind way.
- People and relatives told us staff were kind and caring towards them. One person said, "I like staff. They are nice and kind." A relative said, "I always found staff respectful and very kind."
- We observed staff treating people with kindness and respect when talking to them. However, people had limited input in their care. In some instances, care plans had information about people's likes and dislikes, although this was not used in practice to make people's experience living in the home more pleasurable or were incorrect. For example, a person told us they did not like a certain type of fruit. Their care plan detailed that staff should offer them this fruit as snack.
- Some people living in the home had different cultural backgrounds, religion and beliefs. There was little to no information available for staff to know how to personalise care and support for these people.

Respecting and promoting people's privacy, dignity and independence

- People and relatives, we spoke with, told us staff respected their privacy and dignity.
- Some care plans we reviewed detailed if people could physically participate in their care and for staff to support their independence.
- However, one relative told us, "They [staff] don't walk with [person] enough. They use the wheelchair because its quicker. [Person] needs to build up their strength and mobility but I don't think they are doing it." Another person told us they were sitting all day and not walking much.
- We overheard some staff at lunch time speaking about "feeding people". This did not promote people's dignity.

We recommend that the provider ensures staff are trained and demonstrate a good understanding of equality and diversity as well as how to promote people's dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not receiving personalised care and support. Care plans were not personalised, and staff had little guidance and support from the registered manager to enable them to support people in a person-centred way. For example, symptoms for conditions people lived with were generally listed and not personalised to people.
- For some people their likes and dislikes were recorded under "daily lifestyle" although this information was not used to ensure people received support in a person-centred way. For example, a person liked to have a shower every other day, however records showed they had not had a shower for four weeks. The provider's quality manager told us this was a recording issue, however there was no evidence that this person received a shower and not just a body wash.
- People told us there were not many opportunities for meaningful occupation. When we asked a person what they were doing all day, they said, "Nothing! Absolutely nothing. I sit all day and I am bored!" Another person answered, to the same question, "Not much."
- On the day of the inspection there was nothing planned for people to occupy their time. Relatives told us they have seen an activity staff member on some occasions playing board games with people, however mainly just music was playing on TV for people to listen to.
- Opportunities were missed to enable people to enjoy the things they liked to do in the past. For example, a person had been passionate about cooking and they were talking about this often. Staff missed offering opportunities for the person to still be involved in cooking or food preparation.

This was a further breach of Regulation 9, person-centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Care plans detailed if people could communicate verbally. Further improvements were needed to ensure staff were aware of what alternative methods of communication they could use in different situations, like if people lost some abilities to understand or speak.
- We observed staff communicating with people well and they used visual prompts for people at lunch time

to help them choose the meal they wanted.

Improving care quality in response to complaints or concerns

● Concerns and complaints raised with the registered manager were documented. Complaints recorded were responded to in line with the providers complaints policy, however learning or actions resulting from these were not shared with staff or implemented effectively.

● People we spoke with told us they were talking to staff if they had any concerns. Relatives told us they were confident in talking to staff and discuss any concerns.

End of life care and support

● People were not always involved in planning for the future and what they considered important when they were nearing the end of their life. Care plans to plan for people's end of life care were often limited to recording if people had made a decision about wanting or not to be resuscitated.

● Not all staff had training to understand best practice, current requirements and expectations when supporting people nearing the end of their life.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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 had not demonstrated a good understanding of duty of candour. They were unaware that when things had gone wrong there was a need for them to be open and transparent with people, relatives and external partner agencies about what went wrong.
- We saw things had gone wrong for some people's care, but the registered manager did not adopt the duty of candour principles. Where significant incidents or injury had occurred, staff informed people's relatives, but the registered manager was unable to demonstrate how they then provided a true account of what happened, what further enquiries or investigations were needed. They had not met with the person to review what happened and share any learnt lessons.

This was a breach of Regulation 20 duty of candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Broxbourne Nursing Home admitted their first person in June 2022. Our evidence reported across all sections of this report demonstrate the provider had failed to ensure the basics of training, support, clinical care, dementia care and effective governance and oversight were in place to keep people safe from harm. Managers were not clear about their roles and responsibilities. Staff were not clear on their roles particularly as a number of agency staff were used who were not familiar with the home. At the point of opening, systems were not in place to ensure people received a high-quality care that would be sustained by strong leadership and governance.
- Following our first visit to the service we raised our concerns with the provider who removed the registered manager from the service, transferring them to another of their homes. The quality improvement manager and deputy home manager assumed interim management of the home.
- The registered manager and management team failed to effectively use the providers systems to assess and monitor the quality and safety of the service provided to people. They failed to identify the issues found during the inspection. The registered manager was unable to extract some of the key information required for this inspection from the electronic care planning system. They were not aware of how to operate the system effectively, which impacted on their ability to maintain oversight.
- The registered manager was supported by a regional manager and quality team. They relied on information received from the registered manager and had not assured themselves that people received

safe care through their own robust audit. Although audits around quality and safety had been carried out, they had not identified, captured or managed risks. Opportunities to improve care had been missed on several occasions. The provider had failed to address consistently poor practice in relation to the management and oversight of the home.

● Root cause analysis of incidents, accidents were not imbedded in practice therefore these repeated. The providers quality audits accepted the registered managers findings and did not seek to further assess and probe existing measures in place to mitigate risks. For example, around a lack of training for staff, lack of clinical supervision, failings in relation to managing people's support needs, risk assessments and incomplete or lack of details in care plans.

● The registered manager did not ensure admissions were well planned and safe. The regional director and registered manager had reviewed admissions and identified that risk assessments were not always completed. They did not pause admissions to complete this, but instead proceeded to plan for five admissions within a seven-day period. This increased the risks of people's needs not being assessed and met safely. Neither the registered manager or the regional director considered the need to increase staffing levels to meet the increasing workload for existing staff.

● The registered manager had not assured themselves that staff had the necessary skills and training to provide people with safe care and support. We found that seven agency staff worked at the home without evidence of any training.

● The service was not effectively managed to support the needs of the people living there. We found issues in relation to risk management, infection control, supporting people safely, staff training and support, person centred care and failure to manage in an open and transparent manner. For example, systems for checking pressure mattress were working correctly were completed. However, there was no detail in people's care plan about what the correct setting was. This increased the risk of mattresses being incorrectly set and put people at risk of developing pressure ulcers.

● Learning from incidents, accidents or complaints had not been shared with staff and embedded in practice. At another of the providers nursing homes our inspection found on 23 March 2021 that competencies for nursing staff had not been completed. The provider at that time implemented a system of clinical governance and peer support. However, they did not ensure learning from that inspection was embedded in the management of Broxbourne Nursing Home.

Systems were not effectively operated to ensure people received safe and appropriate care. The provider and registered manager failed to demonstrate leadership, or that quality assurance had been effectively managed. This was a breach of Regulation 17 Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Registered providers must notify us about certain changes, events and incidents that affect their service or the people who use it. The provider and registered manager had failed to notify the CQC of incidents which were notifiable.

Failure to notify CQC is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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.

● The registered manager failed to promote an inclusive and empowering work environment. They did not provide effective leadership, support and supervision for staff. Staff were committed to achieving good-quality care but were limited by a lack of oversight and effective management of the home. Most staff

employed were new to working in care and were not provided with the knowledge or guidance to enable them to provide personalised care and support to people.

● There were daily meetings for staff to discuss people's care and weekly clinical meetings were held by the clinical staff to review people's nursing needs. Clinical meetings lacked detail of what clinical support people needed and what plans were in place for nursing staff to promote people's health and well-being. These meetings did not identify some of the risks to people's health or welfare found at this inspection.

● General staff meetings were held bi-monthly, but minutes lacked any meaningful detail and did not demonstrate positive staff engagement. Meetings were a list of instructions for staff, as opposed to being a forum where issues were discussed and shared actions agreed. Lessons learned were not discussed in these meeting and staff were not informed of key areas of risk, for example increasing falls or incidents between service users.

● There was yet no formal survey carried out to ask for people's feedback about the care they received. There had been a resident and relative meeting where people discussed the menu with staff. However, people and relatives told us the menus still needed to improve.

Working in partnership with others

● The provider met regularly with the local authority commissioning team who commissioned an agreed number of nursing beds in the home. However, these regular supportive meetings had not been used as a meaningful forum to review the admissions and identify areas that required improvement. The local authority acknowledged that the admissions to the service had not been well managed by either the service, or the wider local authority and hospital discharge teams. When people were referred by the discharge teams to the service, consideration was not given to the complexity of needs being referred and pressure was placed on the registered manager to accept people into the service.

● During the inspection there were external health professionals reviewing people's mental health needs and nutritional needs. People's health needs were also reviewed by a GP when it was needed.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager had failed to notify the CQC of incidents which were notifiable.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and the registered manager failed to ensure people received the support they needed. Pre-admission assessments and care plans were not always completed when people moved in the home and did not identify all the needs for some people. People were not receiving personalised care and support. Care plans were not personalised, and staff had little guidance and support to enable them to support people in a person-centred way. Opportunities were missed to enable people to enjoy the things they liked to do and occupy their time.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were poorly completed, lacked sufficient details, and for some people were not completed when required. Consent arrangements were not always in place

to authorise staff to share personal information with people's relatives, who had then made decisions on people's behalf.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager and provider failed to ensure all risk assessments were in place and measures to mitigate risk were detailed to help staff keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager failed to ensure safeguarding concerns were reviewed, investigated and reported appropriately left people at risk of harm. The culture operated by the registered manager did not ensure lessons were learned to minimise the risks of recurrence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered manager had not demonstrated a good understanding of duty of candour. They were unaware that when things had gone wrong there was a need for them to be open and transparent with people, relatives and external partner agencies about what went wrong.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager was unable to demonstrate how the staffing levels were kept under review to ensure these were

appropriately managed to accommodate people's choices. Effective checks of temporary staff were not always carried out before they started to support people in the service.

Staff were not supported to develop their knowledge or reflect on their practice, and they did not all have the appropriate knowledge, skills, or training to provide safe and effective care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 Systems were not effectively operated to ensure people received safe and appropriate care. The provider and registered manager failed to demonstrate leadership or that quality assurance had been effectively managed.

The enforcement action we took:

A warning notice had been sent to the provider for them to make the necessary improvements within a specific time frame and esnure people received safe and quality care.