Care Quality Commission

Mrs Marian Parkinson and George Patrick Parkinson

Broadview

Inspection report

245 Brompton Farm Road
Strood
Rochester
Kent
ME2 3NW
Tel: 01634 717295
Website:

Date of inspection visit: 30 November 2015
Date of publication: 29/02/2016

Ratings

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

Overall summary

The inspection was carried out on the 5 November 2015 and was unannounced.

Broadview provides accommodation for three people with learning and physical difficulties, who require personal care and support. The accommodation is provided in a single storey detached bungalow. There is a communal living room, kitchen, three bedrooms and communal bathroom. Outside there is a good size garden which people have access to. There were three people living in the home when we inspected.

A previous inspection took place on 9 September 2014 and found concerns over Safeguarding people who use services from abuse, management of medicines and assessing and monitoring the quality of service provision. We asked the provider to take action. At this inspection we found improvements had been made.

There was a registered manager employed at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like

Summary of findings

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 home is run.

People at the home told us that they felt safe. There were safeguarding policies and procedures in place that were being followed and staff were fully aware of their responsibilities in reporting safeguarding incidents and what the procedures were for this. There was a whistleblowing policy in place and staff told us they knew how to use it if they needed to.

Recruitment practices were not always robust. The provider's policy was to only explore the last 5 years in employment history and there were large gaps in employment history on some staff files. We have made a recommendation about this.

There was no formal way of assessing dependency levels of people living in the home in order to determine the correct staffing levels to meet people's assessed needs. Some people required one to one care. Staffing rotas showed that at night there was only one member of staff on duty but they had access to an on call system if they needed assistance.

People had been involved in planning for their care needs. Care plans provided information and guidance for staff on how to support people to meet their needs. Risk assessments were robust; clearly identify risks and what to do to mitigate those risks.

Staff had received training specific to people's health needs, such as training in administration of epilepsy medication and PEG feeding. Training considered mandatory by the provider was up to date for all staff.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager and staff had a clear understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff had received training on Deprivation of Liberty Safeguards and the Mental Capacity Act 2005. Care plans evidenced that people's capacity was taken into account and how this affected the care they received from the home.

There were policies and procedures in place for the safe use and administration of medicines. People had access to GPs and other health care professionals. Prompt referrals were made for access to specialist health care professionals.

People were supported to help themselves to snacks and drinks throughout the day. Staff told us that people were involved in choosing what they wanted to eat by helping order the food shopping on line. People with special dietary requirements were catered for.

Some people had lived at the home for a very long time and staff knew them very well. We saw and heard staff engage in meaningful and kind conversations with people.

Some people were encouraged to be independent, but there was no evidence that people who were less mobile were encouraged to be independent.

There was a clear, easy read complaints policy and procedure in place but not all details of the relevant authorities were included. We have made a recommendation about this.

The registered provider had sought the views of people living in the home as well as other stakeholders. The results of the latest survey were used to make necessary improvements.

The quality assurance and monitoring systems in place were robust and allowed the registered manager to established areas that needed improvement. Action plans had been drawn up from the audits and the registered manager was making required improvements.

Staff talked about an open culture and promoting the visions and values of the home. The registered manager was aware of their responsibilities in reporting to CQC and was up to date with current legislation. They kept up to date with best practice and proactively researched their field to make improvements to the lives of people living at the home.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The home was safe.

There were safeguarding adult's procedures in place and staff knew how to recognise abuse and what to do should abuse occur. Risk assessments were robust, identified risk and how to mitigate it.

There was a whistleblowing policy in place, which staff would follow.

The provider did not fully explore gaps in employment history.

There was a medicines policy and procedure in place. The home had identified recording issues on Medical Administration Records and taken action to rectify this.

Is the service effective?

Good

The home was effective.

Staff had completed induction training and received training that was relevant to the needs of the people living in the home.

Staff had a clear understanding of the Mental Capacity Act and the principles behind Deprivation of Liberty Safeguards and how they should be applied to support people living in the home.

People's health needs were being met and medical intervention was being sought when needed.

People had access to food and drink throughout the day.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and dignity. People's privacy and dignity was respected.

People's confidential information was securely kept.

People were consulted about how they wanted their care delivered and were able to make their own decisions.

People were encouraged to maintain relationships with friends and family.

People's cultural and religious beliefs were upheld and supported.

People's end of life wishes were discussed and recorded.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People's care plans were individual and person centred. The plans were reviewed and updated regularly.

Some people were encouraged to be independent.

There was a complaints procedure in place in an easy read format.

Not all people in the home were involved or encouraged to participate in meaningful activities.

Is the service well-led?

Good

The service was well-led.

There were robust quality monitoring systems in place to identify areas requiring improvement. The registered manager acted on any areas to make improvements to the service provided.

There was an open and transparent culture within the home.

Staff were aware of their responsibilities in relation to their role and how to support people.

The registered manager and registered provider were aware of their responsibilities in notifying CQC of any incident of serious injury.

The registered manager proactively researched best practice, regularly attended conferences and worked with outside agencies.

The registered provider and registered manager sought out the view of people using the service.

Broadview

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 was planned to check 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 home under the Care Act 2014.

The inspection took place on the 5 November 2015 and was unannounced. The inspection team consisted of one inspector. Before the inspection we reviewed previous inspection reports and notifications. A notification is information about important events which the home is required to send us by law. We looked at safeguarding and whistleblowing information we had received.

We also spoke with three staff including a support worker, the homes Housing Coordinator and the registered manager. We spoke to one person who lived in the home. We contacted health and social care professionals to obtain feedback about their experience of the home.

We observed care and support being provided. We looked at records held by the provider and care records held in the home. These included two people's care records, risk assessments, staff rotas, three staff recruitment records, meeting minutes, policies and procedures, satisfaction surveys and other management records.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe in the home. One person told us that they felt safe at the home and the fact that the home is on one level with no steps makes it feel even safer.

There was a safeguarding policy in place for the home which made reference to the latest Kent and Medway Safeguarding Vulnerable Adults Protection Policy. Staff were able to identify the different types of abuse and able to describe what they needed to do in the event of any concerns. All the staff had completed training in safeguarding vulnerable people. The home had a whistle blowing policy in place and staff told us that there was a staff hand book which detailed the policy and the phone number to call in the event that they needed to use it. Staff told us that they would have no concerns in using the whistleblowing policy if they had to. Staff were aware of their obligations in keeping people safe and what to do in the event abuse should take place.

There were risk assessments in place for people identifying and mitigating risk. People living in the home had various complex health issues some of which posed a significant risk to their own health as well as staff working in the home. Records showed that when people's behaviours escalated increasing the specific risk to them, GP's had been contacted, blood tests carried out and their health had been monitored. There were risk assessments to try and mitigate the risk of physical violence towards staff. Risk assessments were reviewed and updated as and when people's needs changed.

The home had environmental risk assessments in place which were regularly reviewed and updated. There were gas and electrical safety checks in place that were in date. Staff handover records showed that checks on the premises took place on a daily basis for fire hazards, the security of the garden, house, any faults and damages. Fire safety drills were carried out on a regular basis with people and the fire alarm was checked on a weekly basis. Emergency Life Lines were checked regularly to ensure they continued to work effectively. The personal evacuation plans in place for people detailed how to support them to evacuate the building in the event of an emergency. People were protected from harm from environmental risks and emergency situations.

Accidents and incidents were recorded and responded to appropriately for individuals. One person had tripped during the night. The home responded by ensuring that by working with the person, their room was decluttered to reduce the risk of another incident happening again. Items had been removed from the person's room with their involvement and permission during the decluttering process. People's safety and needs were being monitored and responded to accordingly.

The Registered manager told us that there was no formal way of assessing dependency levels of people in order to establish if there was enough staff on duty to meet their needs. Some people in the home had very complex health needs and care plans evidenced that they needed two to one support. Specifically there was a moving and handling plan that had been signed by all staff clearly stating that the person required two people to safely move them. Staffing rotas showed that during the night there was only one member of staff on duty. We spoke to the registered manager and they told us that there was an on call system in place. Staff could call if they needed help at night so assistance could be obtained quickly if needed. The registered manager had ensured there was access to adequate staffing levels at all times.

The provider had a recruitment policy in place however recruitment practices were not always safe. Interviews were carried out and references were gathered. Staff had been vetted before they started working at the home through the Disclosure and Barring Service (DBS) and we saw evidence of this on staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider's policy was to only seek clarification in gaps in employment history going back 5 years. There were gaps in employment history for one staff files we looked at. In another file we saw the application form had not been fully completed with employment history since leaving school. There was a gap in employment of 16 years that had not been explored at interview. The registered manager was not following its own policy or the guidance provided by the Commission.

We recommend that the provider reviews its recruitment policy taking into account the guidance under schedule three of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

Requires improvement

Is the service safe?

Medicines were stored, administered and disposed of safely. All medicines were stored securely in a locked cabinet, only accessible by suitably trained staff. Medicines were signed into the home and a record made on the medication administration record (MAR) sheet. There was also a section on the MARs for any returned medicines that were no longer required. Staff handover sheets documented that the temperature of the fridge used to store some medicines was checked daily. There was an evening check list signed by a member of staff on duty to say that medicines had been given that day and the MAR sheet had been signed and checked. Records showed that an in house medicines audit was carried out on a weekly basis. However, these audits were not signed by the person carrying them out. Stock controls of medicines were written on the side of the box and the home had identified that this was not a robust stock control procedure. Staff told us that this had been identified as an issue and the paperwork was due to be updated accordingly by the end of the month. In house quality assurance audit's identified that some signatures were missing off some MAR sheets and there was an action plan in place to rectify this.

Training records showed that 100% of staff had completed training in medication awareness Staff knew the correct procedure to follow should an error occur. People received their medicines from staff who were competent and confident to administer medicines safely.

Good

Is the service effective?

Our findings

People told us that they were happy with the way staff looked after them. People told us "The staff work hard". They also told us "I like the food, sometimes we get to choose."

Staff had been through a thorough recruitment process and had completed an induction and probationary period set by the provider. Records showed that training considered mandatory by the provider had been completed and was up to date for all staff. This included Moving and Handling, Safeguarding Vulnerable Adult, Infection Control and Food Hygiene. People living in the home had complex health needs such as epilepsy. All the staff had completed training specifically in epilepsy and administering emergency medication for this condition, should it be needed. They had also all completed PEG (percutaneous endoscopic gastrostomy) feeding training. Staff had received training that was relevant to their roles and to enable them to support the needs of the people living in the home.

Staff had received regular supervision and appraisals. Records showed that the supervisions were being carried out as per the provider's policy. Staff's personal development and training was discussed as well as health and safety issues in the home and staff, company and policy updates. This meant all staff received effective support and supervision for them to carry out their roles.

The manager and staff had a clear understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs). Staff told us that people living in the home were subject to a Deprivation of Liberty Safeguards order (DoLs) and that there were best interest meetings held in respect of these safeguards. They understood the processes involved and that mental capacity assessments needed to be carried out in order to establish if a DoLs was required. The registered manager had applied to the relevant authority to request DoLs authorisations for people as appropriate. The DoLs for some people had expired and the registered manager was aware of this and the need to reapply for the authorisation and this process was in place. Training records showed that all staff had completed training in the Mental Capacity Act 2005.

Staff we spoke to talked about gaining consent from people living in the home. Some people living in the home communicated with nonverbal signals and staff knew when people were happy to consent to treatment or when they wanted something. For example if someone didn't want to go into the lounge and stay in bed they would go rigid and staff knew that that they wanted to stay where they were. This meant that staff new people well and that they knew how to gain consent from people even if they were not able to speak.

People had been involved in the drawing up of their care plans where they were able to participate and had signed their agreement to the plans in place. However, not everyone was able to participate in this process. In this case their family members were heavily involved in the care planning. The care plans recorded the discussions with family members as well as their signature in agreement to the plans. There was evidence of meetings between the home and the funding authority or Continuing Health Care team. People's care plans showed that people had been referred to the epilepsy specialist, psychiatrists and dentists when appropriate. The registered manager and staff responded quickly to people's changing health needs. For example, people's medical appointments had been brought forward because of a change in their health needs.

The different needs of people living in the home had been clearly identified and thorough risk assessments were in place. People's allergies were identified. There was guidance from health professionals in people's care plans. For example, that specified people needed a certain amount of fluid intake during the day. Records evidenced that the fluid intake was being recorded and monitored correctly. Where people were diagnosed with epilepsy staff were provided with clear guidance on signs and symptoms to recognise and action to take should a seizure occur. Plans were in place to meet people specialist needs such as different types of epilepsy.

For some people it was important that they didn't have too much fluid intake during the day and there this was being monitored. Minutes from staff meetings talked about strategies that had been discussed between the staff group and then actioned. This included placing a notice in the bathroom that the water from the bathroom taps was not drinking water. Staff were more able to monitor the

Good

Is the service effective?

person's fluid intake when this person went to drink from the kitchen taps. This strategy was put in place for staff to support the person to manage their condition and was a prompt for that person not to drink from that tap.

People that were able to helped themselves to tea, coffee and snacks throughout the day. People would make drinks for other people living in the home. One person told us "I like the food, especially the roasts and hot curries." We saw records of people making their own porridge for breakfast. We looked in the kitchen and there was plenty of food in stock, including fresh vegetables and fruit. Staff told us that they did on line shopping for food with people living in the home so they could choose what they wanted. Some people living in the home had special diets such as soft foods and PEG feeding. These were catered for and staff spoke about cooking foods that those people with special diets could eat and liked as well as those not on special diets.

Some people's weights were monitored and recorded on a regular basis unless people had declined to be weighted meaning the registered manager was monitoring the health of the residents.

Good

Is the service caring?

Our findings

People told us that the staff were caring. They said "All the staff are marvellous, they are nice and friendly." One care manager told us 'The manager and the staff all appear to give 100% care and compassion to client's and families.'

Throughout the inspection we observed staff talking with people living in the home in a kind and respectful manner. We heard them having meaningful conversations with all the people living in the home. People were seen to be comfortable with staff and staff knew people well. For example, staff were able to tell that one person wanted a drink from the nonverbal signals that they gave.

Staff were able to tell us how they protected people's dignity and privacy. "When we provide personal care we always tell people what we are about to do. We take our time and we never rush people. We respect people's wishes." We observed staff knocking on people's bedroom doors before entering. We read in the staff meeting minutes from July that there was a suggestion for a privacy curtain to be put up for one person to give them more privacy when they were in their bedroom but with the door open. However, this had not been actioned by the registered manager but took place following our inspection.

Staff knew about confidentiality and only to share information with those where it was appropriate to do so. People's care plans and confidential records were kept locked away and only accessible to staff that needed access to those plans. Staff records were kept off the premises but were made available for the day after our inspection.

Support for people living in the home was individualised and their likes and dislikes were recorded in the care plans. There was no evidence of people's family histories recorded in care plans but staff spoke in great detail about people's history's and families. The staff demonstrated they knew people well and had spent time getting to know them and their families.

People were able to make choices about their every day care. One person told us "I do make my own decisions." We saw some people spending time in their rooms and then later in the day spending time in the communal areas. People told us they could go out and said "I ask if I go out, but staff come with me." During the day of inspection one person went out to the shops. People were able to make decisions about how they spent their time and how they liked to be supported by staff.

People's cultural and religious views were taken into account. One care plan showed a specific request for no male carers. There were no male carer's working in the home at the time of the inspection. People had opportunities to practice their religion and people of different faiths were supported by people coming into the home for prayers.

People were encouraged to maintain relationships with family members and other friends, where there were still family involved. Staff told us about people having friends at the home for a birthday tea. One person had been out of the home to visit their relatives at home.

People's bedrooms were individually decorated, with their own furniture and with lots of personal effects around them. Staff told us that the bedrooms were regularly redecorated with the discussion and consent of people living in the home. People were able to watch television in their bedrooms if they didn't want to go into the communal lounge.

Care plans had end of life plans in place for those people that it was appropriate for. There were DNAR's (Do Not Attempt Resuscitation) in place and all of the documents were kept with hospital communication passports. It was clear to see what the wishes of people were at the end of their life and how they wanted to be supported.

Requires improvement

Is the service responsive?

Our findings

People told us that staff were response to their needs. One person told us "If I'm poorly they take me to see the doctor." In the Stakeholder Questionnaire Feedback for November 2015 one person said what the home does well is that they are 'Caring when clients are unwell or need hospital visits.' A health care professional told us 'In my experience of the provider (Anchor) they will always try to find alternative and appropriate accommodation and support should a client's needs change. The one client I have there was transferred following a deterioration in health needs and mobility on the suggestion of Anchor and with the involvement of care management, the client and their family.'

One person had lived in the home for over twenty years so their original assessments were not in their care plans. In other care plans we saw plans from where people had lived in other services prior to moving into the home. Care plans were written and specific to people. We could not see people's personal histories but we could see their likes and dislikes in the records that we looked at. The plan's had a section about people's religion and how their beliefs needed to influence the care that they received.

Staff responded quickly and in a timely manner to people's changing health needs. Staff spoke about a deterioration in one person's health. This person was due to be reviewed by health care professionals and appointments had been brought forward at the request of the home in order that this person could be fully supported with their healthcare needs.

Care plans were regularly reviewed and updated. The funding authorities for people were involved in those reviews, as well as family members. Reviews for certain procedures that people needed were being carried out on a regular basis and care plans were updated accordingly. People were supported and cared for with up to date guidance.

Activities for people were not regularly recorded in people's care plans or daily notes. For example, staff told us that people regularly went out on a weekly basis with them to go shopping and have tea, but only two activities had been recorded for that person from the start of November until the date of inspection. Some people had started to carry out activities outside the home in the local community in previous months, but that person no longer wanted or felt they could continue with those activities. Staff talked about actively trying to encourage people to continue to participate in activities, and other health care professionals were offering support in this area.

There were other people living in the home that were less mobile and although one person regularly visited their family, there was no evidence that they were actively participating in meaningful activities in the home. People had access to a television in the communal lounge and they had televisions in their bedrooms. Some people did drawing and staff told us that sometimes people spent time in the garden although they couldn't remember the last time people had spent time there. The registered manager and staff spoke about people enjoying activities once they were out of the home, but that it was difficult to encourage them to go out. There was no record in care plans that they had tried to encourage them, and that they had declined to participate. Internal quality assurance audits for July and August 2015 established that there was no way of recording people's activities and that a new log had been put in place. The audit in October 2015 established that people who were actively mobile had activities recorded but for them but for those less mobile nothing was recorded. Not all people living in the home were participating in meaningful activities and meant they might be at risk of a lack of stimulation and of social isolation.

Failure to provide activities and stimulation for people in order to meet their individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to an easy read guide to the service. This gave details about the home and the service. There was also an easy read complaints policy and procedure in place which gave clear guidelines on how people could complain and information on when they could expect a response. It contained details of who people could contact in the event that they were unhappy with the homes response to any complaint. This included details of the Local Authority and the Care Quality Commission. It did not contain details of the Local Government Ombudsman. Records showed that the home had not received any complaints in the last 12

Requires improvement

Is the service responsive?

months. However, we spoke to staff and the registered manager and they were very clear about their responsibilities to report concerns and complaints and were able to tell us the process.

We recommend that the provider reviews its complaints procedure to include all relevant authorities that people can escalate complaints to.

Good

Is the service well-led?

Our findings

We received positive feedback from health care professionals that provided support to people. They told us that the home appeared to be well led when they carried out visits to those they provided support to.

The registered manager had systems and processes in place to audit and monitor the quality of the service. This included monitoring the risks relating to people and staffs health and safety. There were regular quality assurance audits carried out by the provider. These audits were designed to monitor the home in line with the Care Quality Commission's key lines of enquiry methodology. Audit's focused on people's files, health and safety and staff files. Audits in July 2015 established that the date for the week commencing were not being consistently noted on the Medication Administration Records (MAR). August and October's audit's confirmed that this was now being done. July's audit had picked up that people's food diaries were not being fully completed. August and October's audit's confirmed that they had been completed in those months. The quality assurance systems in place were robust and enabled the provider and registered manager to identify areas of concern and identify what improvements were needed.

The registered manager told us about their responsibilities, and that these were to the people living in the home and to the staff. They told us they were always on call. They were aware of their reporting responsibilities to the Care Quality Commission about incidents such as DoLs notifications and safeguarding incidents and had sent in notifications to CQC as appropriate.

Care staff were aware of their roles and responsibilities in providing support to people. Staff spoke about an open culture at the home, with visions and values that celebrated people, allowing people to live as unrestricted as possible, and to ensure that the home was not institutionalised. The provider's mission statement set out the aims under which they would provide support to people. From observations staff were proactively promoting dignity, privacy, diversity and independence for people.

Staff told us that the registered manager and the provider were very approachable. Minutes from staff meetings evidenced that when staff had concerns they felt able to bring these up and discuss them openly. For example, there were concerns raised over some people's behaviour towards staff. Senior staff then put in place behaviour plans that the person could see and staff could refer to if behaviours escalated. This helped staff when they were supporting this person when their behaviour became challenging towards them.

The management team at the home included a registered manager and a housing co-ordinator. The registered provider visited the home on a regular basis and staff and the registered manager said they felt well supported by the provider. We spoke to the registered manager about how they kept up to date with new research, guidance and best practice. They told us that they regularly attended conferences on relevant subjects. They read and researched articles on subjects such as behaviours that challenge. They had implemented techniques such as tactical ignoring. This strategy was put in place by the staff to try and de-escalate people's behaviour that was becoming increasingly challenging. This strategy might not have worked all the time so the registered manager had sort intervention and support from outside agencies such as psychologists. They spoke about working with outside agencies such as Speech and Language therapist in order to support people living in the home. One health care professional told us 'There had been issues in the past with the time it took to report issues and the quality of the writing and information. The manager and staff worked through this with the care management team.' The registered manager worked with outside agencies to improve their learning and make improvements as required.

The registered provider regularly sent out stakeholder questionnaires. The results set out in an easy read format what people thought the provider did well and what they didn't do well. It set out with an action plan, what they intended to do in order to make improvements based on the responses to the survey, as well as including these actions in their business plan. A full copy of the responses to the survey was available upon request. The provider was transparent and willing to take on board negative feedback in order to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: This failure to meet people's activities needs. Regulation 9 (1) (a) (b) (c)