Broadlands Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 24 January 2017 and was unannounced. It was carried out by one inspector.

Broadlands Nursing Home provides residential and nursing care for up to 25 people. At the time of our visit there were 16 people using the service. 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.

At our last inspection on 14 July 2016 we found three breaches of legal requirements in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, and fit and proper persons employed. The provider wrote to us with their action plan on 25 August 2016 and told us they would resolve these issues by 17 October 2016.

The purpose of this inspection was to check the improvements the provider said they would make in meeting legal requirements. At this inspection, we found that although the provider had made some improvements to the safety and quality of the service, they were still in breach of the regulations in relation to safe care and treatment and fit and proper persons employed.

Upper floor windows at the top of a communal staircase were still not fitted with appropriate restrictors to protect people from risks associated with falling from height. The restrictors in place were not tamper-proof and could be easily removed.

The provider was still not obtaining all of the information about staff that is required by law as part of recruitment procedures. They did not have appropriate systems in place to ensure a full work history was obtained for each member of staff.

We are taking further action against the provider for a repeated failure to meet the regulation in relation to safe care and treatment. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The provider had made some of the improvements that were necessary since their last inspection. They installed a cooling device to help ensure the room where medicines were kept was cool enough to store medicines safely. They also moved bins containing used razors from bathrooms into a secure room where people could not access them. They had put in place an accident and incident register that helped the registered manager identify any trends in accidents and incidents to help prevent reoccurrence.

The provider had taken action to ensure they were meeting legal requirements when people were deprived of their liberty as part of their care. They applied in a timely manner to the relevant bodies when they

required authorisation to deprive people of their liberty and where these were granted, staff made sure they met any conditions attached to the authorisations. This helped to ensure restriction or deprivation of people's liberty was in their best interests and as least restrictive as possible.

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 provider has not made all the improvements they said they would make following our last inspection. People were at risk of falling from height because windows were not adequately restricted. The provider did not have robust systems in place to ensure staff they recruited were suitable and of good character.

Medicines and hazardous waste were stored safely. There were systems to review and analyse any trends in accidents and incidents.

Is the service effective?

Requires Improvement

The provider has made improvements and was meeting legal requirements where people were deprived of their liberty as part of their care, to help ensure this was in their best interests and as least restrictive as possible.

We could not improve the rating for 'Is the service effective' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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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 service under the Care Act 2014.

This inspection took place on 24 January 2017. It was unannounced and was carried out by one inspector. Before the inspection we reviewed the information we held about the service. This included the previous inspection report and the action plan the provider sent to us. We also reviewed statutory notifications. These contain information that care providers are required to send to us about significant events that take place within services.

During the inspection, we spoke with the registered manager, two people who used the service and one member of staff. We looked at two care plans, two staff files and other records relating to the care and treatment of eight people. We also looked at records relevant to the management of the service, such as accident and incident records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found a breach of the regulations in relation to safe care and treatment and fit and proper persons employed. People were at risk of coming to harm through contact with used razor blades in accessible containers in bathrooms and through falling from height because appropriate window restrictors were not fitted to a large window at the top of a communal staircase. The room where medicines were stored was too hot, which meant there was a risk that people's medicines would be damaged. We also found there was no system in place to monitor and analyse accidents and incidents, meaning it was unlikely that any patterns or trends would be noticed quickly and appropriate action taken. Staff recruitment procedures were not sufficiently robust because the provider did not always obtain suitable evidence of conduct in previous employment and a full employment history, which is a legal requirement when recruiting staff.

At this inspection, we found that the provider had not replaced the window restrictors, which were not suitable because they were not tamper-proof and could easily be removed by hand. This meant people were still at risk of coming to serious harm through falling from height.

The provider continued to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked employment records for the two members of staff the provider had recruited within the last year. The provider had obtained suitable references, but one member of staff who had started work since our last inspection had not provided a full work history or explained gaps in their recent employment history. This meant the provider was still not meeting legal requirements in relation to recruitment. We also noticed that a checklist the provider had placed in each staff file to help ensure all the necessary information and documents were present did not include checks of their employment history. We discussed this with the registered manager, who spoke with the member of staff during our inspection and obtained the necessary information from them. The manager also said they would review the recruitment checklist to ensure all requirements were met in future.

Although the registered manager obtained the necessary information during our inspection, the provider continued to be in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because their systems were not sufficiently robust to ensure staff recruited in the future were suitable to work with people. We will look at this again at our next inspection.

The provider had made the other improvements they said they would make in relation to safe care and treatment. There was a cooling device installed in the room where medicines were kept to help ensure the room remained at a suitable temperature. Although our inspection took place in the winter and the room was cool, we checked daily records of temperatures in the room and found that they had remained within the acceptable range since our last inspection.

We checked all bathrooms and toilets and found that sharps bins containing used razors and other

hazardous items were no longer kept in these places. Staff confirmed they now kept sharps bins in a locked room to which people had no access.

The provider had put in place an accident and incident register, where all accidents and incidents were listed in a table by date with the name of the person involved. This was helpful in identifying when one person had several accidents, for example if someone had multiple falls. We also noted that the nature of the accident or incident was not included on the register and that only the name of the person affected by the incident was recorded rather than the perpetrator where applicable. This meant that where a person had physically attacked others five times in two months, this was not easily identifiable on the register because the victims were different people and only their names were recorded. However, the registered manager told us the pattern had been identified through staff meetings and handovers and the person was no longer using the service. The manager told us they would review the accident and incident register to make this sort of trend easier to identify.

Requires Improvement

Is the service effective?

Our findings

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At our last inspection we found a breach of the regulation in relation to safeguarding people from abuse and improper treatment because the provider was not adhering to the requirements of the DoLS Code of Practice. Where the provider had put an urgent DoLS authorisation in place, they had not applied to the relevant authority to extend this when it expired and had not taken any other steps to ensure the person was deprived of their liberty only in their best interests and in the least restrictive ways possible.

At this inspection, we found that although the local authority responsible for the person's care placement had still not carried out the relevant DoLS assessments, the provider had done all they could to speed up the process. They had applied for an extension of the urgent DoLS authorisation, had written several times to the authorising body in an attempt to speed up the process and had asked a different local authority if they were able to take on the case instead. We saw evidence that a DoLS assessor was due to see the person on the day of our inspection. The person's care plan was regularly reviewed to check whether it was possible to employ any less restrictive ways of caring for them. Staff carried out assessments of the person's mental capacity to check whether they had regained the capacity to consent to care and treatment at the home.

We checked DoLS authorisations for seven other people and saw that applications had been made and granted in a timely manner. Where people had conditions attached to the authorisations, we found that the home was meeting these. For one person, a condition attached to their DoLS authorisation was that staff should offer each Sunday to support them to go to church. Staff originally recorded when they did this but had stopped doing so three months before our visit. The registered manager assured us that staff still offered this activity but had stopped recording it because the person always refused. The manager said they would tell staff to resume the records to provide adequate evidence that they were meeting the conditions set out in the DoLS authorisation.

The two people we spoke with told us there were no unnecessary restrictions on their freedom. They told us, "We're all right" and "It's lovely here."

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 Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not effectively operate recruitment procedures to ensure that persons employed for the purposes of carrying on regulated activities were of good character. Regulation 19 (1)(a) (2)(a)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was reasonably practicable to mitigate risks to the safety of people using the service. This included ensuring the premises were safe. Regulation 12 (1)(2)(b)(d)

The enforcement action we took:

We served a warning notice to the provider to be compliant by 17 February 2017.