Care Quality Commission

Florence Lodge Health Care Limited

Broadwindsor House

Inspection report

Broadwindsor House, Broadwindsor
Beaminster, Dorset DT8 3PX
Tel: 01308 868353
Website: www.broadwindsorhouse.co.ukm

Date of inspection visit: 6 and 12 November 2014
Date of publication: 13/05/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
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 took place on 6 and 12 November 2014 and was unannounced. We last inspected Broadwindsor House on 28 November 2013. At that inspection we found the service was meeting all the essential standards that we assessed.

Broadwindsor House provides accommodation for up to 21 people in 16 single and 2 shared rooms (7 with en suite facilities). People need support with their personal care. The home provides support for mainly older people, including people living with dementia. The home is a large, converted period property with accommodation provided over three floors. The home has accessible grounds and gardens. There were 13 people staying at the home at the time of inspection.

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 and associated Regulations about how the service is run.

The home was comfortable, clean and spacious. We recommended the provider consider how the

Summary of findings

environment could be better adapted to meet the needs of people living with dementia or sensory impairment. There was limited signage or visual cues to guide people about their location or promote interest or reminiscence within the home environment. Improvement was needed to ensure people's needs for stimulation and meaningful activity were met. The care plans gave good detail about people's interests and about ways in which each person could be engaged. However some people told us they would like to have more going on within the home or opportunities to go out more. We saw that efforts were made by the provider to hold events or trips from time to time, for example, which related to the season, however one person told us, "The care here is excellent but it gets very boring sometimes."

People were able to see their friends and families as they wanted. There was plenty of space within the home for people to mix with others, sit quietly or have visitors in private. One person told us, "I thoroughly enjoy being left alone to do my own thing". People and their relatives spoke highly of the service. One person told us, "it's very nice here and I have settled here very quickly." A relative told us, "the care here is excellent of my relative and of me. My relative is very vocal and would say if they had a problem."

We found the service was effective and care was delivered in line with people's individual care assessments. The care plans provided suitable guidance to helped staff understand each person and meet their health and welfare needs in a personalised way. The staff referred to the care plans to help meet each person's needs safely. People told us they felt staff knew how to provide their care.

Staff sought people's consent before offering care and patiently explained how they would assist them if needed. The registered manager and deputy manager understood their responsibilities to assess people's mental capacity. A formal process was in place to ensure staff considered people's best interests, with their representatives, if they were unable to give their consent to decisions about their care and treatment due to their mental impairment. Where people could not give valid consent to living in the home, formal safeguards had been applied, in accordance with the Mental Capacity Act 2005. This helped to ensure that restrictions on people's liberty for reasons of their safety and wellbeing had been properly assessed.

People were treated with kindness and respect. Staff took time to speak with the people they were supporting and there was a calm and relaxed atmosphere in the home. We saw many positive interactions and people enjoyed talking to the staff in the home. People had a choice of meals, snacks and drinks, which they told us they enjoyed. Mealtimes were well organised and people had been involved in planning menus. Their feedback about the meals in the home and their choices was listened to and acted on.

The home was maintained to a clean, hygienic and safe standard. Regular checks of the premises and grounds took place to ensure compliance with all relevant guidance and legislation relating to health and safety. The provider told us that work had taken place to modernise some areas of the home and ensure optimum comfort for people, especially where they had mobility needs. This work was on-going and included internal decoration and improvements to bathing and shower facilities.

The home was adequately staffed including more experienced senior staff on duty as part of the rota. Staff worked as a team, communicating regularly during their work and using time effectively at handover to ensure important information was passed on to promote consistent care for each person. For people not well enough to join people downstairs or who chose to remain in their rooms, staff made sure they did not become isolated. For example, they visited their room to offer drinks, eat with them or sit and chat. There was a strong presence of the registered manager and deputy manager in the areas where care was being provided which helped to guide and support staff and monitor the quality of the service.

The provider had ensured relevant checks on new staff had been carried out. New staff completed induction training, the level of which depending on previous experience. The staff were aware of their responsibility to protect people from harm or abuse. They knew the action to take if they were concerned about the safety or welfare of an individual. They told us how they would report any concerns to a senior person in the home.

Summary of findings

The home had not received any formal complaints and people we spoke with told us they felt able to voice their concerns. We heard people expressing their thoughts and opinions towards staff and visitors.

Medicines were managed safely. Safe systems were in place for handling and storage of medicines and medicines were administered in a person centred and discreet manner.

Staff sought professional advice from healthcare professionals when needed and worked with people's families to arrange access to treatment and advice as needed.

The registered manager provided leadership and was developing the staff team according to their experience and skills. Roles and responsibilities within the staff team were well understood and staff told us they felt comfortable giving feedback to the manager. The quality of the service was checked and actions taken to respond to issues or problems raised by people, their relatives, and staff, through the monitoring checks or through the local authority contract monitoring process. The registered manager was supported by the provider and they were aware of the need to improve meaningful activity for people and told us they were addressing this.

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?

Good

People who lived at the home were safe because there were enough staff to support them.

Staff were recruited safely.

Staff in the service knew how to recognise and report abuse.

Medicines were managed safely.

The home environment was maintained to hygienic and safe standards.

Is the service effective?

Good

People benefited from a service where staff received appropriate training and supervision to provide the care they needed.

Care was delivered with people's consent, in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Meal times and drinks were organised to meet people's dietary needs and preferences.

People saw health and social care professionals when needed to make sure they received appropriate care and treatment.

Is the service caring?

Good

People were treated with dignity and their privacy was respected.

Staff spoke with people and supported them in a positive and friendly manner which helped to promote their well-being.

People, or their representatives, were involved in decisions about their care and support and care plans reflected people's wishes.

Is the service responsive?

Requires Improvement

Improvement was needed, so more opportunities were created for people to take part in activities of their choosing or to socialise with others as set out in their care plan.

The home environment needed improvement to better cater for people with dementia or sensory impairment.

Each person had a care plan based on an individual assessment which was reviewed regularly and changes were noticed and acted upon.

A complaints procedure was in place and whilst no formal complaints were recorded for the last year; people we asked said they would be comfortable to make a complaint.

Summary of findings

Is the service well-led?

Good

The registered manager encouraged open discussion with people, staff and families about the service and knew about concerns expressed by people.

The quality and safety of the service was checked.

There were plans in place for on-going improvement in how the service responded to meet people's needs.

Broadwindsor House

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.

The inspection took place on 12 November 2014 and was unannounced. The inspection was carried out by a single inspector. Before the inspection we gathered and reviewed information from a number of sources. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvement they plan to make. We took account of this information when we made the judgements in this report. We reviewed a local authority contract monitoring report dated August 2014. This information contributed to the planning of this to plan the inspection.

During the inspection we spoke with eight people who lived in the home and five visitors including people's relatives. We spoke with nine members of staff, including the registered manager and nominated individual. We observed care and support in communal areas, spoke to people in private, and looked at care and management records. We looked around the premises and at relevant records for the building. We spoke with two district nurses and a member of the contract monitoring team from the local authority. We looked at six individual care plans and associated records. We also looked at information about staff training, the staffing rota, health and safety and records of checks related to premises and equipment, and at three staff records.

Good

Is the service safe?

Our findings

There were enough staff to support people safely. The service had been advised in August 2014 by the local authority contract monitoring team that staffing may be too low at certain times of the day to meet people's needs safely. People's needs were met safely at the time of inspection as the provider had changed the staffing to ensure there were always a minimum of three care staff on duty. Two support staff were also on duty for part of the day. People told us they felt safe and that they did not have to wait long if they called for assistance. We observed there were enough staff to meet the needs of people in the communal areas and people who remained in their rooms.

The local authority contract monitoring team had also identified that some recruitment records for new staff were not robust. They found for example there were gaps in employment history and some staff did not have references. The provider had brought the staffing and training records up to date following the contract monitoring visit. The files for each member of staff contained evidence of the relevant checks including references from previous employers, previous employment history and Disclosure and Barring Service (DBS) checks.

Staff knew how to report abuse. Staff we spoke with could describe different aspects of abuse and knew what safeguarding adults meant. They told us how they would recognise and report abuse how they would report concerns outside the service if they thought people were not being protected, for example to the local authority or the Police. There were no on-going safeguarding investigations. We looked at safeguarding investigations which had been carried out over the last year and saw the registered manager had put in place procedures and guidance to reduce the risk of repeat events.

Staff were trained in how to manage risk and follow risk management protocols. Specific tools were used by staff, guided by the registered manager and deputy manager, for monitoring and managing risks related to aspects of people's health and well-being. For example, some people's weight was closely monitored because they were at risk of losing weight; some people had care plans specifically around their skin care or psychological well-being, where risks had been identified. All staff told us how they followed these risk assessments and risk management plans when managing complex needs. These included assisting people who could not walk or stand independently, assisting people to eat and drink, or managing behaviour which could put the person, or others, at risk. We observed staff carrying out instructions which were clearly documented on people's care plans, designed to keep the person and members of staff safe whilst care was being given. For example, we observed one person who needed two people to assist them in moving. As they expressed anxiety and nervousness, the members of staff responded patiently and confidently, following the care plan in how they reassured and helped the person to remain calm in order to keep the person safe. We observed that the risk assessments helped to guide the staff and gave them confidence to manage risk safely.

People's medicines were managed safely. Arrangements for prescription, collection, storage and return of all medicines were set out in a procedure which was understood by the staff who had particular responsibility for overseeing this area. There was a staff member who took the lead for overseeing the set process was followed for the administration of medicines and entering this on individual records which were up to date with no gaps. There were written protocols for the administration of 'as required' medicines such as pain relief. There were separate charts for recording the application by staff of creams or the administration of eye drops. Medicines management was individual and person centred.

People benefitted from living in a clean and safe environment. The home was maintained to hygienic standards. All areas of the home were visibly clean and smelt fresh. Equipment was clean. The registered manager was the named infection control lead. The member of staff responsible for cleaning told us about the routine for cleaning arrangements and who was responsible for different areas of cleaning.

A record of accidents and incident was kept with explanations. For example, it was noted that someone who became restless at times as part of their condition, over a specific period of time was causing a higher number of falls and this was attributed to an infection. Instructions were recorded for how to assist people, prevent accidents and what to do if any changes were noticed.

Good

Is the service effective?

Our findings

People received effective care and support to meet their needs. Staff were trained and supported in how to provide the care people required. Induction training had been provided for newly recruited members of staff and was being provided on a refresher basis for existing staff. The training was provided through a variety of methods including shadowing staff, including senior and management staff, over several days, through online training modules or DVDs alongside questionnaires or workbooks which had to be completed. People told us they thought the staff knew how to look after them.

A contract monitoring visit by the local authority in August 2014 identified some shortfalls for some staff in training on equalities and diversity, and safeguarding. It was also identified that some refresher training was required for some staff in areas such as moving and handling. Other areas of training were recommended by the local authority including pressure area care, end of life care and catheter care. Since then the registered manager had produced a training plan and we saw a record showing which staff had now received training in these areas. The majority of staff had received training this year in the areas of promoting continence and catheter care, pressure sore prevention and dementia awareness. We confirmed with four staff on the day of inspection they had received this training. The registered manager told us the format of training included training by qualified staff who had been trained to give this, DVDs and on line training. This helped to ensure staff knowledge and skills was up to date in the areas of care they were responsible for carrying out. All staff had received fire training. The training staff were enabled to take part in helped to develop and maintain their competency.

Staff were encouraged in their professional development. All were qualified to a minimum of level two of the national diploma in the relevant occupational standards, or had studies in progress. Staff told us they took part in one to one supervision every two months. The registered manager told us that staff were also enabled to take part in regular group discussions to share problems and promote team work. This was reflected in our discussions with staff who told us they felt supported and part of a team. The training, supervision and support given to staff helped to ensure they were competent, confident and felt supported to meet the needs of people living in the home. One relative told us that the staffing had become more consistent and this helped to make the service caring because staff got to know their relative's needs. They told us, "They get to know our relative and their ways; even when quite challenging, they are very patient."

People's rights were protected. We observed staff seeking consent from people before helping them and delivering care and support in accordance with their preferences, which were recorded on their care plans. Staff had received appropriate training in the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 is a law that protects and supports people who may not have the capacity to make all decisions for themselves. Deprivation of Liberty Safeguards (DoLs) is a part of the Mental Capacity Act 2005 (MCA) and aims to protect from being unlawfully deprived of their liberty. The safeguards can only be used when there is no other way of supporting a person safely. The registered manager showed understanding of the code of practice relating to the Deprivation of Liberty Safeguards. Applications had been submitted to the local authority, as the supervisory body for these safeguards to be considered in respect of eight people.

Where people had been assessed as unable to make some decisions related to their care, a best interest decision making process had been undertaken and recorded. For example, one person who had equipment to help keep them safe but could not consent to using this had a best interest discussion and decision recorded in their care plan about this. This included the views of relevant professionals including the occupational therapist, a relative and the registered manager.

Meal times and drinks were organised to meet people's dietary needs and preferences. We observed people enjoying their meals. We heard four people express their satisfaction with the look and taste of the food. People were relaxed and comfortable in the dining room which had a pleasant and calm atmosphere. People were offered a choice of where they sat and what they liked to eat. The chef was knowledgeable about people's preferences and dietary needs. The chef asked people what they wanted and responded to people's tastes and food preferences. We observed that food looked appetising and hot. Staff were on hand throughout the mealtime to offer people assistance where needed.

For people who needed help or encouragement with their meal, one to one assistance was given in a patient and

Good

Is the service effective?

considerate manner by a member of staff. A member of care staff was able to tell us which people had their food and drink intake monitored and the reasons why. For example, due to a risk of poor intake or an infection. This helped to ensure people who needed assistance or who were unwell were prompted appropriately and their diet was monitored to encourage a sufficient nutrition and hydration.

People were supported to maintain their health. Care plans contained details of contacts such as family, GP, professionals and other important parts of the person's network. Each of the care plans we reviewed contained comprehensive information about people's health and any medical conditions. Instructions and guidance were clear about all aspects of personal care and any risks associated with this. This helped to ensure the service to people was effective in meeting their needs Staff made regular observations and records about people's condition and any changes, for example in relation to skincare and any weight changes. People saw health and social care professionals when needed to make sure they received appropriate care and treatment. Records were made of visits to the home by professionals who also advised staff about care and treatment. A staff member gave us an example of someone we observed with complex communication needs and how they worked with expert advice to guide them in how to adapt their approach. This information was used to update care plans as required. Three of the people we spoke with were having or had recently had medical or nursing care. They were informed about their condition, able to tell us about their appointments and who helped them to get the treatment they needed.

Good

Is the service caring?

Our findings

Positive relationships had developed between staff and people. Staff showed warmth towards people, for example, acknowledging their thoughts and opinions. One person complained to a member of staff about another person and we saw how the member of staff acknowledged this, and then gently told them they would discuss it in private with them. This was readily accepted by the person.

People's life histories had been recorded including factors or events or previous experience of care, which would be relevant to supporting and promoting people's physical and mental wellbeing. Family members had been involved in this. Where people were relatively new they were helped to feel at home. One person told us they felt comfortable even though they had not been there very long. One member of staff told us, "here we have time to get to know each person and have time to interact with individuals.' This helped staff to understand how to support each person's emotional and psychological wellbeing.

People were treated with dignity and respect and this was shown in how staff took time to chat with people, even if only briefly, and to check on their well-being. When assisting people, staff demonstrated a calm assured approach which produced a calming effect on people.

We observed staff being patient and understanding in responding to one person's mental health needs. The person was gently encouraged to receive assistance with their care and given time to respond. People were relaxed and expressed positive feelings about their environment and the staff, for example, one person told us, "I love looking outside at the beautiful scenery."

People were able to see their friends and families when they wanted. Visitors we spoke with told us they were made welcome by the staff in the home. One person told us they enjoyed poetry and that staff sometimes read with them as they didn't always have the energy to read as they would like to. Another person who was unwell and unable to get up was visited regularly by staff who read to them.

People were supported towards the end of their life to be comfortable and pain free. The home worked closely with healthcare professionals to ensure they had the right guidance and support to meet people's needs. They involved the relatives or representatives of the person. For example, we saw how care was adapted to each stage of one person's needs and how full account was taken of their wishes and those of their family. Staff showed sensitivity towards and understanding of rapidly changing care needs, working closely with specialists as needed. Detailed and time specific records were kept to ensure there were no gaps in care and staff and relatives knew when there had been any changes. This helped to ensure that the experience at end of life was kept as positive as possible.

Requires Improvement

Is the service responsive?

Our findings

Most people did not have enough to occupy or stimulate them during the day. We observed five people in the communal area who were sleepy and inactive throughout most of the morning. When we spoke with people, they readily made conversation. Although staff interacted kindly with people during this period, this was focussed on brief enquiries about their wellbeing or to carry out tasks. Two people told us they got bored as either there was nothing to do or no one to chat to. Care plans contained information about people's social and occupational needs, with positive suggestions about how people could be engaged in different activities however access to opportunities was limited. The registered manager and nominated individual told us they were seeking to recruit an activities organiser to develop a full time programme however they wanted to ensure this member of staff would have the necessary skills and experience.

There was limited signage or visual cues to prompt people about the function of different parts of the building. We noted that people were remained seated throughout much of the day over two days of inspection. The building had not been adapted for people with visual or cognitive impairment and therefore people's independence was not always promoted.

Each person living at Broadwindsor had an individual care plan personalised to each person's needs and preferences. The registered manager told us of recent changes they had made so that staff had a system that was simple and effective, and which helped them to provide support to people. Care plans contained information which was written in a respectful and person centred style reflecting input from people and their families. Guidance was given for staff about how to meet each person's needs in a range of specific areas from night care, sensory impairment to emotional wellbeing. People's care plans had been regularly reviewed. The reviews noted changes or events which were relevant for the person over the last month, including any advice or instructions given by healthcare professionals. This helped to ensure care remained responsive throughout changes to people's needs.

Staff paid attention to and noticed people's needs, either by observation, sitting with people or discreetly asking people how they were. We saw that attention was paid when someone expressed discomfort at the meal time with their wheelchair and intervention was made quickly to relieve the person. In the afternoons staff told us they had more time to offer people one to one. We observed this taking place, for example people played board games one to one or sat and chatted together. Three of the relatives told us they felt they were kept well informed of any changes affecting their relatives, and that communication had improved since the registered manager was appointed in December 2013. We saw that visitors were greeted by the manager when they visited and observed regular phone contact taking place. Efforts were made by the provider to hold events occasionally, to which relatives and friends were invited, for example outside in the grounds in fine weather, or more recently people had been engaged in an event related to Halloween, including making things. People enjoyed sufficient space within the communal areas however to sit quietly. One person told us, "I thoroughly enjoy being left alone to do my own thing."

The service had received no formal complaints over the last year. People told us that if they had any concerns they would speak to the manager or another member of staff. The PIR states that the service had received nine written compliments. The registered manager took time to see people individually throughout the day to listen to any issues and generally enquire how they were. An annual survey was in progress whilst we were inspecting, which consisted of asking relatives and visitors to the home to complete a quality questionnaire, to gain more formal feedback about the service. There was no feedback yet available at the time of inspection. A relative told us, "The care here is excellent of my relative and of me. My relative is very vocal and would say if they had a problem. They always respond so well to this environment."

We recommend that the provider consider current best practice for how more opportunities can be offered for people to follow individual interests and socialise.

We recommend that the service seek advice and guidance from a reputable source, about how the home environment could be shaped effectively to reflect the needs of people living with dementia or visual impairment.

Good

Is the service well-led?

Our findings

The registered manager demonstrated leadership to staff about dignity and respect for people and provided a visible and positive presence throughout the service. They took the time to get to know people and their visitors.
We observed people's positive response, either verbally or with facial expressions or body language.

Staff told us they felt supported and we observed staff communicating and working together positively. The staff structure helped staff to understand their roles and responsibilities. For example, staff told us what was the role of the seniors or who was lead on medicines. The registered manager had started to developing staff into lead roles, where appropriate, to promote a culture of learning, improvement and responsibility. Staff told us they felt they could approach one another and the registered manager for advice or support at any time. This helped to promote a competent and responsive service to people.

The registered manager and provider had worked together to identify on-going improvements. We observed several areas of the home had been decorated and activity was taking place within the grounds to upgrade the external environment. The provider told us in their PIR that the home was a listed building, not a purpose built care home, which led to some limitations with alterations. The registered manager and nominated individual told us how they recognised that more could be done to adapt the environment for promoting the independence of people living with memory or sensory impairment. We noted the actions which had been taken to improve the overall décor and appearance of the home and that this work was on-going. This helped to ensure people could enjoy the benefits of living in a safe and pleasant environment.

The quality of the service was assessed and monitored through a number of checks and audits. The registered manager reviewed incidents and accidents, care plans were reviewed including food and fluid charts and re-positioning charts for people with minimal mobility. The management team used these checks to monitor the safety of the service and ensure risks to individuals were well managed. The care plans of people not as well known to the service, because they had recently moved there, were more frequently monitored. This helped staff to build up a picture of their care and support. Other checks were made about the service including weekly and random audits of stock and medicines, and weekly checks of MARS-individual medicine administration records. Monthly checks of cleaning and observations that procedures for infection control were being followed and checks relating to the kitchen and food hygiene.

The home worked in partnership with other agencies and professionals to improve the care respond to any concerns and take action to prevent the risk of repeat events. For example, improvements had been carried out in how people's mental capacity was assessed, how best interest decisions were taken and recorded and how relative's involvement in decisions was recorded. This was in response to advice and guidance from the local authority social work team and contract monitoring team. We saw that advice from GPs and community nurses was effectively incorporated into end of life care planning for individuals.

The service had worked in partnership with trainee chefs at a local college to produce a cookbook geared for older and retired people. This had provided an opportunity for members of the local community to be invited into the home when this was launched. This helped to promote involvement between different generations, between people and their community and to promote healthy and appealing menus for older people.