Minster Care Management Limited

Broadgate Care Home

Inspection report

108-114 Broadgate
Beeston
Nottingham
Nottinghamshire
NG9 2GG

Tel: 01159250022

Date of inspection visit:
03 April 2018

Date of publication:
20 June 2018

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 3 April 2018; the inspection was unannounced.

Broadgate Care Home is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Broadgate Care Home accommodates up to 40 people in one adapted building. At the time of our inspection 32 people lived at Broadgate Care Home.

At our last comprehensive inspection in October 2015 we rated the service as 'Good.'

At this inspection we found a piece of equipment, which should have been decommissioned due to signs of damage, had been used to help people mobilise.

We have made a recommendation regarding the management of risk.

People did not always have use of their own continence products as staff believed they had none available; this meant there was a potential risk to their skin care.

Required pre-employments checks had not always been recorded as being completed. Checks that nurses' registration with the Nursing and Midwifery Council had been renewed had not been undertaken at the time they were due for renewal.

Although activities were provided and people had been asked about how they enjoyed spending their time, we could not see this had led to satisfying and meaningful activities and interests for all people to partake in.

Systems to assess and monitor the quality and safety of services and reduce risks were not always effective.

The service is required to have a registered manager. 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 the time of our inspection there was a registered manager in post and they were present at the inspection.

People and relatives felt the registered manager was approachable. However some staff reported the registered manager did not listen to them and that he was difficult to talk with.

Surveys of people's and their relatives' views had been completed, however it was not always clear what

actions had been taken in response to this feedback.

Staff were supported with training to provide care in line with the service's aims. However some people experienced poor outcomes as they were unsatisfied with the support provided to pursue activities of interest to them.

Most, but not all people, received care in a timely manner. The number of staff required to provide care for people had been calculated based on people's needs. However, staff had not always been deployed in a way that meant people always received timely care.

People told us they felt safe and staff had been trained and showed an understanding about how people could be at risk from harm and abuse; staff were able to tell us how they would raise their concerns if this was the case.

People had care plans and risk assessments in place. Risks to people associated with their healthcare conditions were assessed and actions identified to reduce any identified risks. Other risks associated with medicines and infection prevention and control were also assessed. Medicines were managed, administered and stored safely. People could have their medicines when they needed them and records were kept of any medicines administration. Actions were taken to reduce risks from infection.

People's care needs were assessed and were in line with current legislation, including the MCA. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People's care involved other healthcare professionals when needed. Staff had been trained to meet people's care needs and staff provided care with people's consent. People received a balanced diet and their food and drink preferences were catered for.

The premises used were suitable for people and had been adapted when needed so people's care needs could be met.

Staff were caring and considerate to people; staff understood it was important for people to feel listened to and spend some quality time talking with staff. Staff showed respect towards people by promoting their dignity and independence. Relatives were involved in people's care when appropriate and records showed people and their relatives' views were reflected in care plans.

A system was in place to monitor and respond to compliments, concerns and complaints. Systems were in place to help any learning from when things went wrong.

People experienced a flexible and responsive approach to their care needs. Staff had been trained to provide care and support when people were at the end of their lives.

Information was available in different formats and people's communication needs were assessed.

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the full copy of this report.

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 service was not safe.

Staff used equipment when it should not have been used due to potential risks. Staff believed continence products were not available for some people. Not all the required pre-employment checks were recorded as having been completed. Staff deployment had not always been sufficient to meet people's needs in a timely manner. Medicines were managed safely and actions were taken to prevent and control infections. Risks associated with people's health needs were assessed and managed. Staff understood how safeguarding procedures helped to protect people.

Is the service effective?

Good

The service was effective.

People's health, including nutritional needs were monitored and responded to appropriately. People's needs and choices were assessed in a way that helped to prevent discrimination and the principles of the MCA were followed; people's communication needs were assessed and met. Staff received training in areas relevant to people's care needs. The premises were suitable for people.

Is the service caring?

Good

The service was caring.

Staff were caring and considerate. Staff respected people's privacy and promoted their independence. People were involved in decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People experienced poor outcomes in relation to the range of activities of interest they were supported to pursue. The Accessible Information Standards had been met. A complaints process was in place to ensure any complaints were investigated

and responded to. Staff had been trained to provide care and support to people when they reached the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were not always effective at monitoring and improving the quality of the service and mitigating risks. There was not a consistent open and transparent culture in the service as staff did not feel listened to and understood. The service was not fully focussed of achieving good quality outcomes for people. A registered manager was in place and understood their responsibilities for the management and governance of the service.

Broadgate Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 April 2018; the inspection was unannounced. The inspection was completed by one inspector, a specialist professional advisor, whose area of specialism was nursing, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in the care of older people.

Before the inspection visit we looked at all of the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Following our inspection visit we asked the provider to send us further information relating to the governance and quality and safety of the service. This was submitted by the provider as requested.

We spoke with the local authority commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. The local authority commissioning team had completed a contract monitoring visit since our last inspection; they made some recommendations to support improvements to the quality of care. We also checked what information Healthwatch Nottinghamshire had received on the service. Healthwatch Nottinghamshire is an independent organisation that represents people using health and social care services.

In addition, during our inspection we spoke with ten people who used the service and four relatives. We also spoke with the registered manager, area manager, two nurses, four care staff, the activities coordinator,

cook, kitchen assistant and two domestic and laundry staff.

We looked at the relevant parts of six people's care plans and reviewed other records relating to the care people received and how the service was managed. This included risk assessments, quality assurance checks, staff training and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when staff provided them with care. One person told us, "I need help to get dressed; I can't manage on my own and two of the staff come together to help me; they are very careful with me." This view was shared by relatives. One relative told us, "I come every other day and I haven't seen anybody fall or being pulled about." However, our observations showed staff used a sling to assist a person to stand. When we inspected the sling we found the stitching was frayed and undone in two places. We made the registered manager aware and he decommissioned the sling. Records showed slings and equipment had been recently tested, however as faults can develop in between tests, staff should make a visual check before any equipment is used. The registered manager told us he expected staff to check equipment prior to its use and confirmed the sling should not have been used due to the frayed and undone stitching. People were not fully protected from risks associated with the use of equipment.

We recommend that the service seek advice and guidance from a reputable source about the safe use of equipment.

Staff told us some people regularly ran out of the continence wear they had been assessed as needing. They told us this had happened to one person on the day of our inspection visit. Staff showed us where they expected the person's continence wear to be; we checked and found there were no items of continence wear. One staff member told us, "It's infuriating; we have to beg, borrow and steal [continence wear]; we were stuck with pant liners at one time." Staff told us they would be borrowing continence wear from other people until a delivery arrived the following day. After our inspection visit the area manager sent us a statement from a member of staff stating there were continence products available for this person; they also sent us a photograph of a store cupboard with continence products in. However, on our inspection visit, staff we spoke with were not aware there was any other continence products available. This meant people did not always receive the correct size and type of continence product that had been assessed as safe for them to use. Therefore we found people were not protected from risks associated with continence care.

We reviewed staff recruitment files to check all the required pre-employment checks had been completed. Nurses are required to register with the Nursing and Midwifery Council (NMC); they are issued with a personal identification number (PIN) that confirms they are registered and fit to practice. We found the registered manager had recorded when nurses' PIN's were due for renewal; however they had not checked these had been renewed. On our inspection visit, two nurses PIN's had expiry dates recorded as over five months previously; another nurse had an expiry date for their PIN as recorded for a month previously. The registered manager had not checked to ensure these PINs had been renewed. They checked on our inspection visit and were able to show us that all the nurses had been renewed their registration with the NMC. We found that one person had a gap in their employment history; whilst the registered manager told us they knew what this was for, there had been no written verification of this employment gap. The registered manager told us they would record any checks on gaps in staff employment history. Evidence to show staff were fit to work at the service had not always been checked in a timely manner and recorded.

We visited one person in their room, accompanied by the registered manager. The person told us they had

used their call bell two or three times in the last hour to ask staff for assistance. They told us staff had come in and turned their call bell off and told them they would be back shortly to help them; however, an hour had passed and they were still waiting for assistance. The registered manager spoke with staff and we saw the person received assistance from staff shortly afterwards. Staff had not always been able to provide timely care for people.

Another person told us, "[Staff] come pretty quickly or they call me to say they'll be there in a minute." One relative told us, "The staff are really good and he doesn't seem to wait long for somebody to help him." Another relative told us, "I think there are enough [staff] but they don't always seem to be deployed properly. There's usually somebody in the lounge with residents but if they have to do something else then there's a big discussion in the corridor about who is free to stay in the lounge."

The registered manager told us staffing levels were calculated based on the level of care people needed. On the day of our inspection visit, the number of staff at work matched the number of staff planned on the staff rota. The staff rotas showed the same amount of staff had been planned to cover weekends and weekdays. However, staff told us they sometimes experienced difficulties with staffing levels at a weekend. They told us when staff had called in sick, the nurse in charge had to spend time phoning round to ask other staff or staffing agencies to cover shifts. They told us this would result in staff having less time to spend with people. Whilst sufficient numbers of staff had been calculated to meet people's needs, the deployment of staff had not always been effective at meeting people's needs.

People told us they felt safe and had not experienced any discrimination whilst living at the service. One person told us, "I feel very safe here; I don't want to go anywhere else." Staff understood how people could be at risk from harm and abuse and were able to tell us how they would report any concerns. Records showed staff had been trained in safeguarding adults. The provider had taken steps to help protect people from abuse.

People told us staff provided care to help them administer their medicines if this was required. One person told us, "The nurse is very good. I had a lot of pain this morning when I first woke up but [the nurse] has been and given me something to ease it; I'm feeling a lot better now." Staff provided people with medicines as and when needed, and followed guidelines in place to help ensure these medicines were given in a consistent way. Some medicines are subject to additional controls and we found these were in place as required. Systems were in place to ensure the medicines people needed travelled with people should they leave the service for an outing or an appointment. Staff recorded the medicines that had been administered and the reason why. We checked other medicines administration record (MAR) charts and found these had been completed as required.

The staff member in charge of medicines administration was knowledgeable on the systems in place to ensure people received their medicines safely. These included the processes for ordering, storage and disposal of medicines. Staff had been trained in medicines administration and management. These actions helped to ensure people received safe care around the management and administration of their medicines. Medicines were managed safely and people's involvement and independence was supported in the management of their own medicines when appropriate.

Staff told us and records confirmed, people had care plans and risk assessments and these were kept under review. These enabled staff to understand what care people required and how to reduce any associated risks, including those associated with falls, nutrition and pressure area care. Where people had specific healthcare needs, such as epilepsy specific guidelines were in place on how to manage any associated risks. Risk assessments were also in place for emergency situations. For example, personal emergency evacuation

plans (PEEP's) were in place for each person and recorded what support people would require in the event of an emergency evacuation. Staff told us, and records confirmed any accidents, incidents and near misses were reported. Actions were taken to improve safety; the service had systems in place to help identify when things went wrong and to identify learning from these incidents to implement further improvements.

People told us they were satisfied their home was kept clean and told us they were happy with the standard their clothes were laundered to. We checked a selection of communal and ensuite bathrooms and found these were clean. Arrangements were in place for clinical waste and the laundry operated in way to keep clean clothes separate from dirty clothes. Staff had been trained in infection prevention and control as well as in food hygiene. We saw staff practised good hand hygiene, for example before they assisted people with their medicines. The provider had taken steps to ensure people were protected by the prevention and control of infection.

Good

Is the service effective?

Our findings

People told us they felt treated fairly and had not experienced any discrimination. One person told us of the arrangements in place so they were able to continue to practice their faith and had regular visits from the leader of their faith community. Assessment of people's needs, including in relation to protected characteristics under the Equality Act 2010 were considered in people's care plans with them. This helped to ensure people did not experience any discrimination. Records showed how people's disabilities had been assessed and what care was required to meet people's associated needs. In addition, other protected characteristics, such as a particular religious belief were identified and steps taken to meet those associated needs. This helped to prevent and reduce the impact of discrimination and helped to meet people's needs under the Equalities Act 2010.

Other assessments of people's care needs were carried out using evidence based tools, for example in the assessment of pressure sore risks. In addition, assessments were completed in line with current legislation, for example decision making was taken in line with the MCA. Where people required specific assessments associated with their health conditions we saw referrals had been made so the assessment could be made by the appropriate professionals, such as referrals made to tissue viability nurses, occupational therapists and speech and language therapists. Assessment processes were in line with current legislation and standards and helped to achieve effective health outcomes for people.

People told us they felt the staff understood their care needs. One person told us, "[Staff] are good; when I have any pain, I tell them and they will help me; they know what to do." Staff told us they received training in areas relevant to people's needs and records showed this covered areas such as first aid, dementia and falls prevention. Some nursing staff told us they could ask for any additional training they felt they needed. They gave examples of training that had been arranged and this covered phlebotomy and catheterisation; they also told us they had attended external specialist training including colostomy and urology care at the local hospital. The registered manager had a system in place to keep track on what training staff had completed and what training was due. The service had provided staff with the skills, knowledge and experience they needed to deliver effective care and support.

Staff were trained in areas of care consistent with the service provided, for example in falls prevention, pressure care and dementia. Staff told us they received regular supervision. Supervision is an opportunity to provide staff members with the chance to reflect and learn from their practice, receive personal support and professional development. Staff told us their supervisions were with either the nurses or the registered manager. Staff told us when they had their supervision with the nurses, they felt supported.

People received food and drinks that met their preferences and needs. One person told us, "I think [staff] will do a few different things at lunchtime; they know I don't like cheese and some meats, so they will always do me something different; they ask me what I want." Another person told us, "I like the food; it's very good." A relative said, "[Staff] always ask me every time I'm here if I would like some lunch; I haven't up to now, but it's nice to know I could if I wanted." Staff we spoke with were aware of people's dietary preferences, for example the foods people excluded from their diet for faith reasons. Records showed people's food and

fluid intake was monitored where this was assessed as required. People received a balanced and nutritious diet.

People's healthcare needs were assessed and they had access to other healthcare professionals when needed. One relative told us, "Communication is really good with us. [Staff] always let me know if [my family member] is not too well; they have had quite a few UTI's (urinary tract infections) and staff pick up on it really quickly." Another relative told us, "I have no worries about healthcare." Staff told us, and records confirmed people had access to other healthcare professionals when they needed them. For example, records showed healthcare professionals such as GP's, tissue viability nurses and occupational therapists had been involved in people's care when needed; GP's visited the service weekly. People were supported with their health care and staff worked with other organisations and other professionals to ensure people received effective care.

People told us staff asked them what help they wanted before care was provided. One person told us, "[Staff] ask me things; they ask if they can come into my room; they don't just walk in even though the door is open." During our inspection we heard staff asking people about their care and offering people choices. Staff we spoke with understood the importance of only providing care to people with their consent.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had policies in place that covered the MCA and making decisions in a person's best interests. When people lacked the mental capacity to make some specific decisions by themselves these had been made in meetings with other professionals and family members when appropriate. These meetings were to discuss what decisions were considered to be in a person's best interests. For example, how best to manage people's medicines. Where appropriate, applications for DoLS authorisations had been made. We found one person's care plan had conflicting information about their mental capacity; we discussed this with the registered and regional manager who reviewed the file and confirmed it had been updated. People's consent to their care and treatment was sought by staff in line with the MCA.

Adaptions, such as handrails to aid people with their mobility were fitted where needed in the property. Areas where there was an identified risk, for example, the kitchen and laundry were kept secure. People's rooms were personalised and people had a choice of different areas to sit within the home. People's individual needs were met through the adaption of their premises when needed.

Good

Is the service caring?

Our findings

People told us they felt staff were caring. One person told us, "The staff are very nice to us." A relative told us, "The staff are marvellous; nothing is too much trouble for them." Staff spoke with warmth and fondness for the people they cared for; throughout our inspection, we observed staff were considerate to people. For example, we heard staff ask a person, "Would you like me to come and tell you when lunch is?" when the person had wanted to spend some time in their room.

Staff we spoke with were aware of how people were feeling. One person told us, "Staff take time to come and sit with me and have a chat which I really enjoy; I like having people to talk to." On our inspection visit, we heard one person tell a member of staff they were upset. The staff member checked what they were worried about and offered them reassurance in a calm and caring manner. When we spoke with staff they told us although they were busy they would make sure they could spend time with people when they needed it; although one staff member said this was more difficult at weekends when changes were made to the staff rotas at short notice.

Throughout our inspection we saw people's privacy was respected and their independence promoted. One person told us, "I am having physio every day; when I am mobile enough to be able to get around my flat I will be able to go home; they are really helping me to get my independence back." People spent time in their own rooms as they pleased. On our inspection visit one person had chosen to watch a film on their own television and another person enjoyed listening to music in their own bedroom. We saw staff knocked on people's doors and waited for people to answer before entering. Relatives told us they were able to visit people freely. Staff told us how they supported people to be as independent as possible. One staff member told us how they helped a person choose what clothes they wanted to wear; they told us it was their choice and they always made sure they showed them a range of clothes to choose from. People's privacy, dignity and independence was respected and relationships with people's families and friends were supported.

Not all people we spoke with were familiar with a care plan, however care plans showed how people had been consulted. For example, people's choices and preferences for care were included in care plans. For example, one person's care plan stated they had been involved with their relative in discussions about their wishes. One relative told us, "I have been involved in the care plan. [My family member] has a DNAR (do not attempt resuscitation) notice which was agreed with my family member; there are reviewed every three to six months." Records showed people's care plans and risk assessments had been regularly reviewed with them. This meant people were involved in making decisions about their own care, and their needs and wishes were met with respect.

Requires Improvement

Is the service responsive?

Our findings

Some, but not all people were satisfied with how they spent their time. One person told us, "I don't go out at all; I like to be in [my bedroom] and as long as I can read and watch my TV then I'm quite happy; I have my meals here as well; I don't like to be in the lounge." However, another person told us, "I want to get out; I'd give anything to get out; it's so boring here; I hate it." A relative told us, "There is nothing to get people motivated here; yes, physical needs are looked after but people are just bored and they give up." Another relative told us, "[My family member] is bored to tears; staff look after them, doing the necessary things but there is no mental stimulation which they really need."

Staff told us they used to be able to take people out for a meal but told us this did not happen anymore. They told us the service arranged for visiting entertainers, such as singers instead; however they told us this was usually one a month. They also told us they held events that celebrated people's different cultures; events held had included a Caribbean day and a Bollywood day. They also told us they knew when people enjoyed listening to certain types of music and would make sure this was available to them in their bedrooms if this was their choice. We saw some art and craft activities were available the morning of our inspection visit but not many people partook. Staff told us they had collected some information on people's life history and interests. We also saw people had taken part in a survey to identify what activities they would like. However we could not see how this had led to people being able to pursue their interests and hobbies and fulfil their goals and aspirations.

People told us other aspects of their care and treatment was responsive to their needs. For example, one person told us, "I usually have a shower on Monday mornings, but I'm not restricted; if I wanted one on any other day I'd be able to have one." We observed staff notice a person had refused lunch and they discussed alternative arrangements for providing lunch with them.

People's communication needs were assessed. Where people had communication needs identified, staff were knowledgeable on how to communicate with people. This helped to ensure any communication needs associated with their health and wellbeing were identified and met in a responsive and individualised way. Records showed information on important aspects of people's care, such as the DoLS was available in large print and as an 'easy read' format. The Accessible Information Standards had been met. The aim of the accessible information standard is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

No one we spoke with had needed to raise a complaint. People told us they knew how to raise any concerns or make a complaint should they need to. The provider had a formal complaints policy in place, to manage any complaints should they be received. Records showed when complaints had been received these were investigated. Processes were in place so complaints and feedback would be handled in a transparent manner and used to inform improvements to the service.

When people required care for the end of their lives, records showed this had been planned with the person and their family; we saw any associated care needs, such as pressure area care had also been considered

and planned for. Records showed staff promptly communicated any changes in a person's condition when they were receiving end of life care. Staff told us they felt well trained in areas such as the use of any equipment involved in the care of people at the end of their lives. People received appropriate care and treatment at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

Most staff told us they did not feel the registered manager listened to them; their comments included; "[The registered manager] is variable, depending on the issue; I've had instances when I've not been listened to;" "Sometimes I raise issues with [the registered manager] and I don't get a good response; I've had instances when he's not listened;" and, "When I've tried to talk with [the registered manager] he'll have no time for you and he'll stare at the computer." However, one staff member told us, "[The registered manager] does listen."

Staff who told us they had supervision with the registered manager told us this was not always helpful. One staff member told us, "Supervision is more of a telling off; I want to be talking; [the registered manager] will point out a load of stuff we are doing anyway; to have a conversation is difficult; you don't get a well-done."

We spoke with the registered manager and regional manager about the feedback we had received from staff. The regional manager told us he would encourage staff to approach the registered manager first with any issue; he also told us staff were also free to contact him directly. Some staff we spoke with told us they had contacted the regional manager and did not report any concerns with them. Shortly after our inspection visit the regional and registered manager sent us a survey they had completed to collect staff views. The results reflected the staff concerns we found on our inspection visit. For example the survey showed 50% of staff felt the [registered manager] was not approachable; only 35% of staff felt fairly treated; only 42% of staff felt valued. The survey was accompanied by an action plan to improve staff morale and tackle the issues identified by the survey. However, at the time of our inspection, staff did not feel listened to or valued. We were concerned that an open and transparent culture was not always promoted as staff felt they would not always be listened to, and they felt the registered manager was not always approachable.

The service's aims were not always clearly centred on the needs of people using the service. For example, although people had been asked how they would like to spend their time, we could not see how this had been used to develop personalised activity choices for people.

People told us they had opportunities to be engaged and involved with how the service was provided. People and their families had been asked for their views on the quality and safety of services. Records showed most people's feedback had been positive, however a number of people commented they had not been involved in the care plan; we could not see how this had been specifically addressed in feedback to people and their families. Steps had been taken so that people and their families could share their views, however it was not always clear what steps had been taken in response to their feedback.

We found systems had not been followed to ensure checks on the registration status of nurses with the NMC had been completed in a timely manner. Staff were unaware of where additional supplies of continence wear were for people. In addition, staff had not identified that a sling had frayed and had areas of undone stitching and had proceeded to use it. Systems and processes were not always effective at assessing and monitoring the quality and safety of services and mitigating risks.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Other checks on the quality and safety of services were completed. Records showed audits were completed on medicines administration record (MAR) charts, infection prevention and control, accidents or incidents and records of people's weight had been analysed for any changes. Records showed the regional manager completed regular visits to review the quality and safety of services provided. These governance arrangements helped to identify any trends, manage risk and provide assurances on the quality and safety of services for people.

People told us, and records confirmed where other professionals had been involved in their care and treatment. For example, we saw where GP's and other health and social care professionals had been involved in people's care when needed. The service worked in partnership with other agencies.

A registered manager is required at Broadgate Nursing Home and one was 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. The registered manager understood when notifications were required and had submitted these as needed. Notifications are changes, events or incidents that providers must tell us about. We also saw the CQC's rating for the service was on display as required.

People and relatives felt the registered manager was approachable. One relative told us, I often see the manager around the home and he is very approachable." We observed the registered manager knew people well and chatted with people as he walked around. Although one relative told us they felt the home was not always well managed. They said, "The staff here are all kind; they do try their best but I don't think they are directed very well."

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 17 HSCA RA Regulations 2014 Good governance Systems and processes were not fully effective at assessing and monitoring the quality and safety of services and mitigating risks. Action had not always been taken in response to people's views in order to improve services. Outcomes were not always focussed on people. An open and transparent culture was not always promoted. Regulation 17(1)(2)(a)(b)(e)