European Care (Danbury) Limited

Broomfield

Inspection report

Broomfield Hospital Site
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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**

Overall summary

We carried out an unannounced inspection on 27 November 2014. The home was last inspected on the 27 February 2014 and was found to be compliant with all outcomes inspected. However there was a suspension in place at the time by the Local Authority, which meant they were not placing people at the service who they funded. This suspension was still in place at the time of our inspection in November.

The home can accommodate up to 140 people but has never been fully occupied and one unit remains unused.

At the time of our inspection there were 55 people using the service and they were supported in three different units. The home is registered to provide accommodation for people who require nursing or personal care, or rehabilitation.

The home has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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 service is run.

On the day of our inspection there were enough staff and staff recruitment and retention had improved in recent months which meant less agency staff usage. However we had concerns that staffing levels were not always maintained or sufficient to the needs of people using the service. We also were not assured that all staff had the necessary skills or were adequately supported in their role.

People did not always receive their medicines safely and these had not been identified by the homes audits which meant they were not as effective as they could be.

Staff were aware of their responsibility to protect people in their care and knew what actions to take if they had concerns about a person's care and welfare. Risks to people had been identified and steps taken to minimise the risk whenever possible.

People's health care needs were met and records showed us that people's health care needs were kept under review. Any changes to people's health were acted upon.

Staff ensured people received adequate supervision for their safety and enough to eat and drink.

Staff were aware of how to meet people's needs and were sufficiently competent. Staff were supported through regular training which helped them meet people's individual needs.

Staff worked within the law to support people who were not able to make their own decisions about their care and welfare.

Staff were caring and upheld people's dignity and independence and respected people's individuality.

Staff were familiar with people's needs but we could not see how staff responded to people's changing needs and people's records did not always reflect a change in need.

There were systems in place to listen and respond to people's concerns and their family members so the service could make improvements to the service as required.

Staff did not all feel well supported and were not clear about the vision and values of the service.

There were systems in place to assess and review the quality of the service provided but not everyone felt this was effective or that they had a say on how the service was delivered.

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 service was not always safe.

Staffing levels were inadequate and increased the risks of people of receiving unsafe care.

We could not be assured people always received their medicines safely because we identified gaps in recording and auditing practices.

Risks to people in respect to their care and welfare were managed safety.

People were protected as far as reasonably possible from abuse because staff understood what abuse was and what action they should take to protect people from actual or potential abuse.

Is the service effective?

Good

The service was effective.

People had access to health care and staff monitored people's health to ensure they remained healthy and, or received the treatment they needed. To promote good health.

People were supported to eat and drink in sufficient quantities to meet their needs.

Staff worked lawfully to protect people who were unable to make decisions about their care and welfare.

Staff had the appropriate skills and competent to meet people's needs.

Is the service caring?

Good

The service is caring because;

Staff knew people's individual needs and responded to them appropriately.

People's privacy and dignity were upheld.

People were given the support they required in a timely, sensitive way.

Is the service responsive?

Requires Improvement

The service is not responsive.

Staff were familiar with people's needs but were not familiar with some people's life experiences which would assist them in providing more person centred care.

People's care records were not up to date, or accurate. This could increase the risk of people receiving the wrong care.

Summary of findings

The service responded to complaints and took into account the views of people and their relatives to improve the service.

Is the service well-led?
The service was not well led

Requires Improvement

The systems in place to monitor the efficiency and effectiveness of the service were not effective at identifying gaps in service provision.

Not everyone felt that they were listened to or able to contribute to the development of the service.

Broomfield

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 27 November 2014 and was unannounced.

The inspection was carried out by two inspectors and a specialist advisor who was a general nurse. In preparation for this inspection we reviewed the information we held about the service. This included, previous inspection reports and information from people who had shared their experiences with us. We also reviewed notifications. A notification is information about important events which the service is required to send to us by law.

During the inspection we spoke with the registered manager, the area manager, the head of care and seven other staff. We spoke with five visitors and ten people using the service. We looked at five care plans and other records relating to the management and running of the service, such as audits to show if the service was managed safely and effectively. We looked at staffing rotas too see if there were enough staff to deliver the care. We carried out observations on each of the units throughout the morning and over lunch to see how staff provided care and support to people.

As some of the people who live in the service live with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. SOFI observations were carried out on each of the units.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that there were not always enough staff on duty. We observed that staff were continually deployed to different areas of the home. Staff told us it was not usual practice to have staff redeployed on the unit at busier times of the day. The rota's we saw did not reflect or plan for these changes. We saw that staffing levels fluctuated throughout the day across the units and saw no evidence that people's needs changed throughout the day.

One person told us, "Staff don't always come to me when I need them to as they are sometimes busy." We observed lunch on all floors and saw a person who had remained in bed had been provided with their lunch in their room. We saw that this person had no encouragement or assistance to eat their meal and therefore their meal went cold and they did not eat. This was because the staff were busy assisting others and did not have the time to help this person.

Staff told us they felt pressurised to come in and work when they were sick and said they worked long hours, which affected their home life/work life. They said at weekends they could be particularly short of staff. One relative said, "My relative's needs are not always met. They need two staff to care for them when they are distressed and there is not always enough staff for this." Another relative told us that they were there every day and saw staff gave their relative time but felt this did not happen when they were not there. Through our observation we saw this was the case which meant the person's needs were not always met.

The manager told us that by using a dependency assessment tool they had assessed how many staffing hours were required to meet people's needs and this was reviewed weekly. They said they tried to have one staff to five people but this ratio was sometimes higher. They told us that all staffing posts were recruited to and they rarely used agency staff so staff were familiar with people's needs. However our observations showed that there were not always enough staff available to meet the people's needs.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Each of the three floors had their own medicines trolley and medicines was stored appropriately and locked away in the treatment room so it was safe. We looked at the way in which medicines were recorded and administered on the first floor. Medicine records gave appropriate information about the people and what they were taking and included a signed photograph to help staff correctly identify the person when administering the medicine. There was also guidance of how people preferred to take their medication, for example if they needed it crushed to reduce the risk of aspiration. Where this had been agreed this was authorised by the GP.

There was a separate record for the administration of cream but we noted that this was applied by care staff and signed for by the trained nurses giving the medication. This is not in line with national guidance which states that the person administering the medicine should sign the chart to confirm administration. We also noted that handwritten entries on the medication records were not counter signed as recommended in line with best practice. Minor discrepancies were seen between what had been signed for as administered and what was left in stock. This meant people may not have received their medicines correctly. This was feedback at the time of the inspection so the manager could take immediate action.

Weekly medication audits were done and errors had been reported. However, we noted a number of additional errors had been made with people's pain patches not being given or given to the wrong person. This meant we were not assured that people got their pain patches as prescribed which meant we could not be assured they were getting appropriate pain relief. Staff told us external medication audits had also been undertaken but could not provide us evidence of this so we could not see if any improvements had been identified.

We had asked the provider for clarification about the use of 'bulk medication' which would be given to people as required as homely remedies and taken as required rather than individually prescribed. The provider said this was agreed with the clinical commissioning group but was not able to provide us evidence of this. We noted when 'occasional' medicines were being administered such as for pain relief the person's medication record did not say why the medicines had been administered and there was no evidence that it had been reviewed when the medicine had been given for a number of consecutive days. Because of the above findings we could not be assured that medicines

Requires Improvement

Is the service safe?

were managed safely and that people received them when needed. This is a breach of Regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives told us they felt safe or their relatives were kept safe. We spoke with a relative who told us their family member was very settled at the home. They said a previous home were unable to meet their needs or keep their relative safe, but felt they were safe in this home. They told us their relative was prone to falls but said staff were familiar with their needs and tried to minimise the risk of injury to them, whilst giving them their independence to walk around freely. They told us bedrails were not suitable for their relative but this had been discussed with them and the staff kept them informed and involved in any care decisions. This meant they had confidence in the staff and the service provided to their family member. We observed staff in the lounge at all times, which meant people choosing to sit there were supervised for their safety and risk from falls were minimised because staff were at hand to assist.

The environment was safe and appropriate to people's needs and risks were minimised. It was spacious and free from immediate hazards. There were rails on both sides of the corridor for people to use to steady themselves. Wet floor signs were used whenever cleaning was taking place to remind staff, visitors and people of the slip hazard.

Risks to people's safety had been assessed and steps put in place to reduce the risk to the person. For example we saw a person who was prescribed warfarin which could increase the person's skin vulnerability. The care record told staff how to prevent this person's skin breaking down. Air mattresses and pressure relieving cushions were being used and this was also recorded in residents care plans.

Care records for one person had identified that they had had six falls in the last three months. The person's risk assessment and care plan had been regularly updated. We saw that a referral had been made to the occupational therapy team which meant their falls were being monitored and evaluated to see what other actions the service could take.

The senior staff on duty was knowledgeable of the fire evacuation procedures and drill within the service so staff would know and practiced keeping people safe in the event of a fire or other emergency. The risk to individual people in the event of a fire or other emergency had been assessed and recorded so staff knew how best to assist them in an emergency to promote their safety.

We observed staff manual handling practices and saw that staff demonstrated good techniques to ensure the person was transferred safely. People had equipment in place where the need had been identified to protect them from the risk of falls and to help them to maintain their skin integrity. There were risk assessments in place for the rationale to use bed rails to ensure they were appropriate to that person and reduced the risk of falls to that person.

All new staff received basic awareness training on the protection of adults from abuse within the first week of starting their employment to ensure that they were aware of what abuse was, how to identify it and what to do if they saw or suspected abuse was occurring. They then completed additional training to further their knowledge which was updated annually. Staff spoken with could tell us what constituted abuse and what they would do if they were told, saw or suspected that someone was being abused. They said they would report it immediately to the manager or the deputy manager straight away to safeguard the person.

Requires Improvement

Is the service effective?

Our findings

We observed people being prompted to drink and eat in sufficient quantities for their needs. People had drinks within their reach and staff actively encouraged people to drink enough for their needs. Snacks were provided throughout the day.

We saw that staff took a great deal of time to ensure people had their meal in a timely way without outpacing people but giving them time to eat their food. Staff gently encouraged people and did not rush them. We noted one person was not encouraged to eat and drink in a timely way which was fed back at the time of our inspection so this could be addressed.

We saw that staff monitored people's weights and managed people's nutritional needs, particularly where there was a risk of dehydration or malnutrition, including food/fluid records, nutritional care plans, current weights and nutritional screening tools to measure the risk to people who could not be weighed. We identified one person at potential risk of not getting enough to eat for their needs and this was passed to the manager to address.

Staff had received training in the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] and showed a good understanding of the legal requirements in relation to capacity. However some people's records did not show us how the MCA was being used effectively in practice which meant we could not always see how staff were working in accordance with the legislation. For example We noted that one person, who was living with dementia, had signed their risk assessments for bedrails to be used. However there was no assessment of this person's mental capacity to make decisions about their care and welfare. We felt this was more a records than a practice issue.

We also identified one person who was being administered their medication covertly. There was a form in place stating the reasons for this and showing a discussion had taken place with the GP and the family. However there was no assessment of the person's capacity to establish if they were able to consent, and there was no evidence that the decision to administer medication covertly had been reviewed. The services medication policy stated that covert administration of medicines should be discussed with the supplying pharmacist and there was no evidence of whether this has happened. This meant we could not clearly see if the service was acting in the person's best interest or following their own medicines policy.

People's health care needs were kept under review and people saw health care professionals as and when they needed to. For example one person's record showed regular involvement with the speech and language department and regular monitoring of their weight. They had also been seen recently by the optician to monitor their eye condition. A risk assessment and care plan was in place for their medical conditions and these were reviewed with appropriate professionals.

Staff had training specific to their role and felt able to carry out tasks competently. Some staff told us they had not had supervision for more than six months, but we did see evidence of staff meetings so staff did receive support and were given the opportunity to discuss their practice and areas for development. We observed moving and handling practices and staff were able to demonstrate safe techniques and understanding of moving and handling regulations.

Trained staff felt well supported and said they had the training to do their job well. Registered nurses were being supported in regards to their clinical professional development and they told us as well as attending all required training and working alongside other skills nursing staff some staff were attending 'train the trainer' courses such as Health and Safety and SOVA. Nurses told us their skills were regularly assessed through skills based competencies. One nurse said they had four supervisions a year and this was helpful. This meant staff's performance was appraised to ensure they had the necessary skills to meet the needs of people requiring nursing care. However another member of staff told us they had not been given all the support they needed following promotion which required different skills. Staff told us about differing levels of support they had received with some saying support was poor. This could potentially lead to differential care being provided and not all staff being developed.

Recent staff meeting minutes showed us what staff training had taken place and in addition to practical training all staff were expected to keep their e-learning training up to date. Staff told us they did this and received enough training for their roles and to enable them to meet people's needs.

Good

Is the service caring?

Our findings

We spoke with one person who told us, “It is very nice here; I am very well looked after.” Another person said, “The food is good, I am quite happy.” People were appropriately supervised for their safety and we saw staff spending time with people and enhancing their well-being through conversation, music and providing stimulus such as a bubble machine which some people were watching. There were a range of social activities taking place on the different units which included ladies getting their nails painted, an organised quiz, staff spending one to one time with people and discussing with them things of interest.

Staff talked to people in a caring and respectful manner. For example, staff made eye contact and listened to what people were saying, and responded accordingly. We observed one person singing and holding hands with the staff member, another staff member was talking to a person about the television programme; another was spending considerable time with a person encouraging them to drink. They were attentive to their needs. Activities provided to people were recorded and evaluated to measure if the activity was successful and met the individual’s needs.

Relatives told us there were different things happening during the day to keep their family members occupied. Such as access to the gardens, which were enclosed and safe, a café on site and various religious services appropriate to people’s specific faith which meant people’s diversity was respected. Relatives told us they were made very welcome by the staff and they were supportive of each other which meant they felt happy to come.

We observed housekeeping staff talking with people who used the service. They knocked on doors and waited to be invited in before entering the room, whether the door was open or closed which meant people’s privacy was respected. Doors were closed during personal care tasks to protect people’s dignity. We heard staff sensitively and discreetly asking people if they wished to use the toilet. People’s records gave a summary of their needs and included aspects of care they could manage themselves, what they needed support with and their personal preferences which helped staff deliver individualised care.

We observed one member of staff assisting a person who had remained in bed to eat their meal. During this time we heard them gently encouraging the person to eat on four occasions. They were sensitive to their needs and did not rush them.

Meals served in the main dining rooms were served promptly and people got the assistance they required to ensure their independence and dignity was respected.

We spoke with people about how they were treated by staff and two people who used the service told us that staff were always polite and caring. Relatives spoken with confirmed this and said staff were helpful and they had confidence in the staff.

Requires Improvement

Is the service responsive?

Our findings

During our inspection one person was shouting out and telling other people what to do. We asked staff about this person as we wondered if they might have had a previous profession in which they managed people. Staff were not able to tell us about this person's history or previous occupation. They were unable to say why this person shouted or how they could minimise this person's distress. Staff did not know the reasons for this person's distress as there was no thorough assessment of the person's needs; this meant they were not responsive to their needs.

Some care plans provided misleading information so we could not be assured staff would respond to people's changing needs appropriately. Where a person's needs had changed the information had been recorded but not all the documentation included the same information which could result in the wrong care being provided. For example, we saw one person needed a special diet because of the risk of aspiration. This was recorded but another record, which had an older date on it, stated they had a normal diet. Staff were aware of this person's needs but a newer member of staff or relief staff might not be which may lead to the person being put at risk chocking. Systems to review records were in place but were not as effective as they could be.

The manager told us that people's dependency needs were regularly assessed and care plans and risk assessments were regularly reviewed to ensure that there was up to date information on peoples care needs. This information was then used to review staffing levels. However the manager then said some of the people's needs on the residential unit had changed and that their needs were more in line with nursing. When asked, the manager informed us that they had not been referred to social services for a re-assessment which meant their needs might not be correctly met and funded appropriately within the service.

We observed through the morning that the only attention one person got was assistance around their meal and going to the toilet. They had a visual impairment. This was recorded in their care plan but the information was at the back of the care plan which meant staff might not be aware of this person's needs when providing care to them. We saw this person sitting throughout the morning, unengaged and without any interaction from the staff. We spoke with this person's relative in the afternoon. They told us, "I don't know what happens when I am not here, I think when they are short staffed my relative might be ignored because they don't demand attention."

We noted that one person had photographs above their chair to show staff how they liked to be positioned during the day. We observed staff seating this person and propping them up with pillows as showed in the photograph. This meant the person's individual needs were met.

Staff were aware of people's needs and showed they were able to help them manage their anxiety. We noted that one person was particularly anxious about their drink asking people not to touch it. Staff noticed this and was able to reassure the person.

We observed a person being supported with their mobility. Staff were responsive to their needs and took time to explain what they doing and gave them time to respond.

Care plans told us what people's needs were and how they should be met by staff. Records showed us that some people using the service and their relatives had been involved in the planning and reviewing of the person's care but this was not evidenced in every record. People's care plans and related documents reflected people's preferences, personal history, interests and where they like to spend their time, who with, where they wished to eat, get up and go to bed.

We saw handover notes completed after each shift so staff going off and coming on duty knew about the people they were supporting and any concerns with their care and welfare which meant they could care for the person effectively.

Family members told us they knew who the management team were and were familiar with the staff on duty. They said they knew how to complain and several relatives told us of their concerns which they had said they raised. Some relatives said they did not always know what had happened as a result of their concerns. They said relatives meetings take place but they do not always receive timely feedback.

Their main concern was around staffing levels and staff leaving, which relatives thought might lead to a decline in the standard of care being provided. Relative meeting

Requires Improvement

Is the service responsive?

minutes showed us the concerns were discussed several weeks earlier. We identified the same concerns, which meant we could not be confident the provider was dealing with concerns raised by people.

Requires Improvement

Is the service well-led?

Our findings

We spoke with staff and relatives about the management of the service. Staff told us that there have been a lot of different managers in recent years. Staff also told us there were problems with the staffing rotas and said staff were expected to work over their contracted hours and often did a number of long shifts in a row without a break increasing the likelihood of them making a mistake because they were tired. Some staff said they felt supported by the current manager whilst others said they did not. Staff said that they were 'performance managed' and were expected to work even if they were sick as otherwise they would leave the service short, and would not get paid.

Staff reported low morale and staffing shortages particularly at the weekend which resulted in people having to wait for care or missing out on activities. Some staff reported a poor skills mix with not all staff having a good grasp of English which made communication difficult. Another said there was not always trained staff on duty so the skills mix was inappropriate to the needs of the residents. One staff told us, "It feels like the home is built on sand."

We fed back our concerns to the manager and area manager. The area manager was new to post and did not seem to be aware of the hours or shift patterns some staff told us they were working. He told us this could be easily rectified. In terms of staffing numbers on shift the manager told us he had been in post a year and in that time had significantly reduced the number of agency staff they were using. He said staff recruitment was on-going and he took into account people's dependency levels and staffed the service accordingly.

Relatives told us they had recently been to a relatives meeting and raised their concerns about staffing levels and staff retention. Some relatives told us previous concerns had not been responded to. Another relative told us the manager was approachable and they felt involved with their family members care. The manager told us they monitored staff turnover to ensure consistency for relative's family members. However, not all relatives were confident their concerns had been listened too.

Staff told us what they liked about the home, they told us, "lovely nice buildings with all the equipment we need." However, they told us that the "staffing rota." Was an area that required improvement? Relatives expressed concern about staff leaving and existing staff working a lot of hours to cover staffing vacancies which relatives felt could affect their family members care as staff were tired.

Staff comments in relation to the culture within the home, were conflicting. Staff told us most of the team worked well together. However, some staff said their concerns and suggestions were dismissed and not acted on making them feel they did not have a contribution to make, demoralised and unable to provide high levels of care. Other staff told us their concerns were listed to. One member of staff said, "I spoke to the manager on Monday about a concern I had, they spoke to me on the Wednesday to update me about the concern."

Some staff told us they received regular supervision which helped them to fulfil their role and meant they felt adequately supported. However other staff told us they had not received a supervision in months and this appeared dependent on who their supervisor was and the fact that a high proportion of staff were part time. This meant that not all staff felt well supported or felt clear about the job expectations. A member of staff told us they felt supported by the manager and said, "I am very happy with general management, his door is always open and if I ask I get every single time." We concluded that some staff felt well supported by the managers and others did not which meant there was an inconsistency.

One member of staff said they felt the supervisions were 'threatening' around the subject of sickness. This was repeated by other members of staff who did not feel supported appropriately or in a way that motivated them. Some said about the manager's approach to them which they felt was heavy-handed.

We saw external stakeholder visits that completed a report of their visit highlighting what the service was doing well and if any improvements had been identified. We also saw that internal audits were completed by the area manager which included sampling records, observing care practices and talking to people using the service. We saw a sample of other audits carried out by the manager including care plan audits which should help them to identify the standard of record keeping and care being provided within the service so they knew where to make improvements and what they were doing well. However we found a lack of evidence about whether people had capacity to consent or how people were involved in their care reviews which

Requires Improvement

Is the service well-led?

meant we could not always see how the service consulted and involved the person. We also found auditing of care records ineffective because some care plans contained contradictory information which could result in the wrong care being provided. For example a person had three falls in four months but this information had not been included in the review of their care plan. This meant care plan reviews were not as effective as they could be

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 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The service did not protect people against the risks associated with the unsafe use and management of medication by way of appropriate arrangements for the obtaining, using and safe administration of medicines (Regulation 13).

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The service did not always provide enough suitably qualified staff in sufficient numbers to meet people's needs.

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.