Peterborough Care Limited

Broadleigh Nursing Home

Inspection report

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Broadleigh Nursing Home is registered to provide accommodation for up to 37 people who require nursing or personal care. The home provides support for older people, some of whom are living with dementia. Accommodation is provided over two floors. The upper floor can be accessed by stairs or lift. The home offers a range of private and communal places where people can relax and receive their guests. At the time of the inspection there were 31 people living at the home.

This comprehensive inspection took place on 4 April 2017 and was unannounced.

At the last inspection on 5 April 2016 a breach of legal requirements was found and the service was rated as Requires Improvement. After the comprehensive inspection the provider wrote to us to say what they would do to meet the legal requirement in relation to improvements to the variety of food that was available to meet people's needs. The provider sent us an action plan telling us how they would make the required improvements.

During this inspection we found that the provider had made the necessary improvements and the legal requirement was now being met. This means that the service is now rated as Good.

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

At the last inspection, undertaken on 5 April 2016, we found there was a breach of one legal requirement because people were not offered an appropriate variety of food that was available to meet their needs. We saw that there had been improvements made to meet the relevant requirement.

The risk of harm for people was reduced because staff knew how to recognise and report any incidents of harm. There was a sufficient number of staff to meet the care and support needs of people living in the home. Satisfactory pre-employment checks were completed before staff worked in the home.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had been assessed. Staff were trained in the principles of the MCA and DoLS and could describe how people were supported to make decisions. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were able to make choices about their food and drink throughout the day. Staff checked that people had sufficient amounts to eat and drink. Staff treated people with care and respect and made sure people's

privacy and dignity was respected.

People and staff were able to provide feedback and information so that the management could monitor and improve the quality of the service. The management team had an open door policy which meant anyone could make a complaint and make comments or improvements about the care and support provided.

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

The service was safe.

People were kept as safe as possible because staff knew how to protect people from harm and how to report any such untoward incidents. There were sufficient numbers of staff to keep people as safe as possible.

People were protected from harm because risk assessments had been written and these were followed by staff to help keep people safe.

People had their prescribed medication administered by staff who had been trained and they had been deemed competent to do so.

Is the service effective?

Good

The service was effective.

People were supported to meet their needs by staff who had the necessary skills and competencies.

Staff had received training and understood the principals of the Mental Capacity Act 2005.

People had access to health professionals when they needed them. People had enough food and drink available and were supported by staff to eat and drink where help was needed.

Is the service caring?

Good

The service was caring.

People were treated with respect and staff were aware of people's likes and dislikes. People were encouraged by staff to remain as independent as possible.

People's dignity and privacy was maintained.

People were involved in the planning and making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People had their care needs assessed and staff understood people and how to meet their needs.

People could choose to be involved in activities that they enjoyed.

There was a complaints process in place and complaints or concerns were investigated and responded to.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place.

There were effective systems in place to monitor and improve the standard of the home. Audits were completed and action taken when necessary.

People and their relatives had the opportunity to be involved in improving and developing the home.

Broadleigh Nursing 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the home under the Care Act 2014.

This unannounced inspection took place on 4 April 2017 and was carried out by one inspector.

We reviewed previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also looked at information we held about the service.

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 improvements they plan to make. We reviewed the information to assist us with our planning of the inspection.

During the inspection we spoke with five people living in the home, two relatives, the registered manager, one senior care staff, one member of care staff, two domestics, the compliance manager, the health and safety manager and provider's representatives. We also spoke with one visiting social care professional and received information from two health professionals.

We spent time observing the care provided by staff to help us understand the experiences of people unable to tell us their views directly. This was because some people were living with dementia.

We looked at three people's care records, quality assurance surveys, staff meeting minutes and audits. We checked records in relation to the management of the home such as health and safety audits and staff training records.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. One person said, "Yes I do [feel safe]. When we need help they [staff] give it – when we do [need assistance] they're there." Another person said they felt safe because they received the medication they needed, which was administered by the staff. One member of staff explained how they ensured people were kept safe. They told us, "We follow the rules and regulations of the home. Conform to the principals of care of the elderly and vulnerable. This keeps us [staff] safe but first and foremost for residents [people who live in the home]."

Staff were aware of the providers safeguarding procedures and who to inform if they had concerns or witnessed people at risk of harm. One member of staff said, "I would immediately inform the nurse [in charge], they will decide on what action to take. I can report also to the directors, CQC or Peterborough [Safeguarding] team." All staff were aware that they could report any concerns to other agencies such as the local authority safeguarding team or the police. There had been no safeguarding referrals since the last inspection. However, on the day of inspection the registered manager dealt with a serious issue. This had been caused by a manufacturer who supplies the feed for people who are fed through a tube into the stomach. As a result a person in the home was at risk of harm but the registered manager took the appropriate measures to keep the person safe. The registered manager followed the provider's policy and said a referral about the manufacturer who supplies the feed would be made to the local authority safeguarding team as soon as possible.

We saw that people's risks had been assessed and these were managed to reduce the level of risk where possible. For example, there were some people who were at risk because they did not eat well. This could affect their weight and skin integrity. We saw that food supplements were provided to people and the type and number of supplements recorded. We saw that people's weights were checked regularly and recorded. Staff told us that any concerns would be reported to the nurse in charge and the tissue viability nurse (TVN) would be called to assess the person. During the inspection one person living in the home had a problem with drinking. We informed the registered manager as it occurred on two separate occasions. The registered manager immediately faxed a referral to the speech and language therapist (SALT) to come and assess the person. This meant people were kept as safe as possible and health professionals were requested appropriately. We received information from both the TVN and SALT that confirmed that they received appropriate and timely referrals from the nurses in the home.

There were fire and personal emergency evacuation plans in place for each person living in the home. This ensured people were assisted safely if ever there was a need to evacuate the premises. Staff were aware of where the plans were to be found and told us there were regular fire evacuation tests. The registered manager confirmed that tests were also carried out so that night staff were aware of the emergency procedures in the home. There had been an independent fire company assessment of the home in January 2017, which had found no issues. This meant that the home was as safe as possible for people who lived in the home, their visitors and the staff who worked there.

During the inspection we found that there were sufficient numbers of staff available to ensure people's

needs were met. People said they felt there were enough staff and that emergency call bells were usually answered quickly. One person said they had had to wait 25 minutes once but that was unusual and said, "It would be better if there were more staff, but they do the work and are always busy." Another person said, "If I call they [staff] come in about five minutes. They could do with more [staff] at busy times like mealtimes."

The registered manager told us staffing levels were monitored on an ongoing and daily basis. If extra staff were required to support people whose health needs had increased, then that was done. We observed during the inspection that staff were available to support people when they needed it. In addition, we found that people's request for assistance using their call bells were responded to promptly. This indicated to us that people were being assisted as requested.

Accidents and incidents involving people had been recorded, reported and investigated and, where necessary, action had been taken and the outcome recorded. This was to help prevent the potential for any recurrences.

Staff told us that they had only commenced working in the home when all the required recruitment checks had been satisfactorily completed. Staff told us that they had provided a number of documents which included an application form, a disclosure and barring criminal records check and references.

Most people told us they felt that the administration of their prescribed medication was safe. People told us that staff 'supervised' them when taking their medication. One person told us that staff prepared the medication, but they (the person) administered it. This meant they continued to be as independent as possible. Another person told us that staff ensured they were kept pain free and administered all medication on time. They also said that they wanted the staff to administer their medication because, "I can get a bit confused."

We saw that the provider had systems in place so that people's medicines were obtained, stored, administered and disposed of appropriately. Staff told us that only nurses administered people's medicines, although topical medicines, such as creams and ointments, were administered by care staff. Regular monthly medication audits had been completed by the registered manager. The last was completed in March 2017 and there were no issues or discrepancies in any medication that had been checked.

People told us that the domestic staff came into their bedroom every day to clean. People commented that the rooms were kept clean and tidy and it was evident that was the case during the inspection. There were no offensive odours throughout the home. One senior member of staff said they were the 'infection control champion' for the home and said, "I had extra training and am active in applying infection control rules; from cutlery, toilets, [people's] bedrooms and general rooms." The domestic staff said there were some days at the weekend when there was only one member of staff, but generally they said there were sufficient staff available to ensure the home was clean. Staff explained how they ensured infection control measures were put in place should they be needed and that they had sufficient cleaning agents, aprons and gloves available.

Good

Is the service effective?

Our findings

At the previous inspection in April 2016 we found that the provider was breaching one legal requirement in this area and was rated as requires improvement. We found at this inspection that the provider had made improvements because people had choices about the food they ate at mealtimes.

There had been improvements in relation to the choice and variety of food available for people. We spent time with people at lunchtime. People were told what the menu was for the meal and staff checked that people were happy with that. There were also pictorial menus that meant people who were unable to recognise written menus were able to see pictures of them instead. People told us they could ask for an alternative such as a sandwich, baked potato or salad. One person said they (staff) would "do you anything you wanted." People were assisted with their meals if they needed it and we heard how staff talked with people whilst doing so. Where people needed help to eat their meal we saw that there was good interaction and people were not hurried when the help was given. We noted that other people were encouraged by staff to eat when necessary. Another person said, "We have our meals in the dining room but can have it in our [bed] room if we want", "The food is fantastic. There is a choice [of meals] but they [staff] will do something else if you don't like it." and "The food is nice. You have a choice. You can have a sandwich if you don't like the two choices." We saw that pureed food was well presented at lunch time, with the meat and vegetables separate on the plate. The registered manager said that the service was awaiting special food moulds for pureed food, which had been purchased. These would provide the shape of the food people were eating e.g. fish shape, vegetables and chicken legs. It would also mean staff were also able to know the food they were assisting people with.

People and their relatives told us there were always drinks available. People told us they were encouraged to drink plenty of fluid. One person showed us that they had hot chocolate, water and squash on their table, and they were very happy with the drinks provided. We saw that there was information in people's care plans about their likes and dislikes for their food and drink.

People and their relatives told us they felt that staff had the necessary skills to meet their needs. One person told us the nurses provided the care they needed in relation to specific medical needs. Another person said, "They [care staff] seem to know what they're doing."

Staff told us they felt supported in their role and that training was provided on a regular basis to ensure their learning and development in their role. Staff confirmed that areas of training expected by the provider, such as moving and transferring people, safeguarding, infection control and medication administration were provided and updated where necessary. Staff also said further training in relation to their roles could be requested and that it would be provided. We saw the training plan for 2017, which showed the different training courses that staff were expected to attend as well as designated courses such as end of life care.

The provider told us that all new staff would be expected to complete the Care Certificate. This training includes a set of standards that social care and health workers must apply in their daily working practice. One new member of domestic staff told us they had completed a basic induction programme when they

first started working at the home.

The Mental Capacity Act 2005 (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.

Staff confirmed they had received training in the MCA and understood how these principles were to be applied to ensure people's human and legal rights were respected. One member of staff said, "If a person doesn't have capacity I talk to the family and make sure to check what the person used to like. I ask if [what we are doing] is all right and they are comfortable with it. People [living in the home] who do not have verbal skills I watch their facial expressions and have eye contact to try to get an understanding. I watch their eyes and if providing choice of meals I watch to see which one they look at."

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 home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. CQC had received notifications that showed people had been referred to the local authority in relation to DoLS. There was information in people's files that showed DoLS had been authorised by the appropriate authority and the manager confirmed that any restrictions on people's liberty were met.

People told us, and care records confirmed, that they had access to health care professionals. One person said that they had the GP visit. Another person told us they regularly attended hospital for their condition and also saw the physiotherapist. People were supported to gain access to other health professionals. We saw information in people's files that showed that SALT's, dieticians and TVN's had assessed some people. One TVN said that staff followed any guidance they gave in relation to individual people in the home. A SALT told us that the nursing team 'know their residents' and had found staff helpful and courteous. Care staff told us that, when needed, they informed the nurse in charge, who would call a doctor.

Good

Is the service caring?

Our findings

People told us that staff were kind and helpful. People were positive about the staff and said, "The staff are absolutely fantastic" and "The nurses are lovely, brilliant." One person said, "Staff are very nice. They are very good to me. They now help me to eat as I have problems to do it myself." Two health professionals said they felt staff were very helpful and respectful of people living in the home.

Staff were able to tell us about individual people. They told us about people's current needs, what they were able to do for themselves and how they communicated if there were issues about language or understanding. One member of staff said, "We enjoy talking to people [who live in the home] and they like talking to us." The staff member was able to tell us about the care two people needed as well as their interests. These interests included attending communion, walking through to the dining room for lunch and enjoying a 'massage' when cream was applied to their body. This demonstrated that staff knew about people and the care and support they required.

People and their relatives told us they felt involved in the planning and making decisions about their care. One person said, "The staff talk to me about my care." They went on to say that they had been part of discussions around bed rails and had agreed so that they did not fall out of bed. We also saw evidence in people's care plans that they were involved in discussions about end of life care where possible. Information in people's files showed that they or their relatives had been involved in their care plans and reviews.

People and their relatives told us the staff encouraged them to remain as independent as possible. One person told us that they had gradually improved their independence and could now put their own clothes on. They commented that it had been the staff support that had enabled them to do so.

People told us that staff did respect their privacy and dignity. There were several comments that staff knocked on people's bedroom doors and waited until the person asked them to come in. Staff told us how they ensured people's dignity and privacy by closing doors and curtains. One staff member said, "I knock on the door and wait. I tell the person what I am doing and ask permission before I assist them."

At the time of our visit the majority of people had relatives or friends who acted on their behalf when necessary. Information displayed in the front entrance and areas in the home gave the contact details of advocacy services if people did not have someone to act on their behalf. Advocacy services are independent and support people to make decisions and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People told us that they had provided information to staff and been involved in their care. Two people told us they had not been assessed before they came into the home on a temporary basis. However, the registered manager told us that assessments for interim beds (for people who came from hospital and intended to return to their own homes) were completed by telephone. Further discussions with people about their care needs were completed when they arrived at Broadleigh Nursing Home.

We saw that people's care plans provided adequate information about the person's needs. We found that although one person had not signed the care plan they agreed that the information was correct. This included their likes and dislikes, how they should be moved or transferred and information on specific health issues. Staff were able to tell us about people they supported, their care plans and knew how to meet people's individual needs. One health professional said that staff knew the people they cared for.

Staff told us information was shared, so that they were kept up to date about changes in people's needs. For example, one member of staff said, "We have to attend the handover [meeting when the shift changes], this is a rule of the manager. These are discussions [about any changes for each individual person in the home] and sharing information of residents." This meant that relevant health or care information was handed over to staff coming on to shift and the information about any changes to people's care was documented.

People told us they were encouraged and provided with a number of different activities, but were able to decline to attend if they so wished. The registered manager said there was a new activities staff member starting the following week. Currently the home had activities staff from other homes (owned by the provider) to ensure there was still an activities programme available for people living in the home. We saw evidence of the activities undertaken in February 2017 such as holy communion, repotting herbs, board games, making cards and other crafts, adult colouring, movement to music, pet therapy and making cakes. One person told us, "I've been in the garden and we also had a [birthday] party out there." Other people told us they liked to remain in their bedrooms and wrote letters, read books or watched TV.

People and their relatives told us they knew how to make a complaint and who they would speak with. They said they had not needed to make any complaints. Information from the provider showed that the complaints policy was sent to relatives as part of the welcome pack for their family member. Staff said they were aware of the complaints policy and knew how they would help people to make a complaint if they wished. Information from the provider showed that health and social care professionals had also been sent information on the home's policy and procedure on complaints as well as the e-mail addresses and telephone contacts for the registered manager and directors of the home.

Good

Is the service well-led?

Our findings

At the time of our visit, Broadleigh Nursing Home the provider was displaying the previous rating. The home had a registered manager in post who was supported by representatives of the provider, a compliance manager who also covered quality and education, nurses, senior care staff, care staff and ancillary staff. The registered manager notified the commission about events that were required by law.

Staff knew who the registered manager was in the home as well as the provider's representatives. Staff told us the provider's representatives came into the home regularly and they had their contact details so were able to speak with them directly, if they needed to. Staff told us the registered manager was very good. One staff member said, "I really like [name of registered manager] she is very kind. If I have a problem I can share it with her, like a friend. She says "Thank you"." Another staff member said, "I like [name of registered manager]. She treats staff equally. I have good communication with her. She is fair with staff and treats new staff with a welcoming attitude." A third member of staff said, "I like to be here, I am settled here."

Staff were aware of the provider's whistle blowing policy and said they would be listened to and action would be taken if necessary. One member of staff told us they had had a "positive reaction" to concerns they had raised.

We received a mixed response when speaking with people about meetings they could attend. Some people (who had only been in the home for a few weeks) were not aware there were any meetings, whilst one person told us they knew of them but had not attended. We saw that there had been a meeting on 8 February 2017 where the topics covered areas such as the explanation of the 'key worker' (the principal member of staff who supported a person) within the home, reviews of care plans and that letters were to be sent to relatives to attend, how to complain and that everyone had the right to do so and information about activities.

Minutes of staff meetings and nurses' meetings showed these took place on a regular basis. Staff told us that the meetings were an opportunity to discuss any issues or concerns, as well as be provided with up to date information on topics such as infection control or new forms that needed to be completed. We saw that staff agendas provided time for staff to raise any other business. The meetings were also used as a forum to ensure that staff understood what was expected of them. Good practice sessions and lessons learned from events and incidents were shared at these meetings. For example, the provider's Health and Safety person always attends the meetings to update staff on things such as photographing wounds and ensuring a care plan relating to each wound was completed.

People were encouraged to feedback their experience of living at the home and to raise any issues or concerns they may have had. People told us they talked with staff on a day to day basis. There had been a quality assurance review in January 2017 and a report compiled. This showed that 11 people had participated and completed the form sent to them by the provider. Information from the report showed that some people had commented that "we could do with more staff" and "I sometimes wait a little longer at

night for the [emergency call] bell to be answered". The provider had checked the call responses on the system on three occasions (one of which was at night) and the longest a person had waited was eight minutes during the day and four minutes at night. The provider also reviewed the staffing levels, agency usage and talked to people living in the service. This showed the provider had responded to comments made by people and investigated their concerns.

There were a number of audits in the home including monthly health and safety checks, which showed where action had been taken. This was in relation to things such as guttering and a tree in the garden. However, in discussion with the health and safety manager, we spoke about the audits on the fire alarm checks. This was because there were some areas that should have been noted and actioned. The health and safety manager immediately made changes and implemented different arrangements in some areas, such as maintenance issues and the method to record and action them. There were monthly registered manager checks that looked at incidents/accidents (to see if there were any themes or reasons people fell), infection control issues, moving and transferring and emergency arrangements. The last check was made on 30 March 2017 and there were no actions required. There were monthly First Aid equipment checks where stock was checked to ensure it was in date.

Documents used to record and monitor people's fluid intake and positional changes were completed. We noted that the expected fluid intake for a person during 24 hours was recorded and had a running total. The record showed the fluid amount offered and the actual amount of fluid drunk. This meant staff were recording accurate information about the fluid a person had. As a result of audits there was up-to-date information in the care plans and risk assessments. This was for those people who required to have their fluid intake checked, that showed when health professionals should be called. We found that staff had done this when required. Where staff had recorded positional changes for people, they had not always used the providers 'turn chart codes'. However staff had written to explain what they had done and this showed people were supported to change position.