Bupa Care Homes (AKW) Limited

Broomcroft House Care Home

Inspection report

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Date of inspection visit:
16 March 2016
21 March 2016

Date of publication:
13 July 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this inspection on 16 and 21 March 2016 and it was an unannounced inspection. This means the provider did not know we were going to carry out the inspection.

Our last full inspection of the home took place on 30 March and 2 April 2015 and we found the home to be in breach of regulations for person-centred care, safe care and treatment, good governance and staffing. Compliance actions were given for these breaches in regulation and the registered provider was told to make improvements. On this inspection we checked improvements the registered provider had made. We found there were still breaches in regulations, therefore sufficient improvements had not been made to meet regulations.

Broomcroft House is registered to provide accommodation for up to 87 older people who require nursing and/or personal care. The first floor of the home is for people who are living with dementia. At the time of our inspection there were 55 people living at Broomcroft House, 26 of whom were living on the first floor and 29 on the ground floor.

It is a condition of registration with the Care Quality Commission that the home has a registered manager in place. There was no registered manager in post at the time of this inspection but there was a person who managed the day to day running of the home. 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 previous registered manager had cancelled their registration on 14 October 2015 and the current manager had been managing the home since that date.

The systems in place for carrying out quality assurance of the service to assure the service were compliant with regulations, identifying areas for improvement and acting on them, had been ineffective in ensuring those improvements and compliance with regulations. This included having information available about how the service had responded to complaints and people's experiences about the quality of care provided.

Care and treatment was not provided in a safe way for people by doing all that was possible to mitigate risks, including the safe storage of medicines that required refrigeration, having systems in place to protect people who may be at risk of avoidable harm from other people's behaviour that also lived at the home, and people's nutritional needs.

People and relatives we spoke with told us staff were caring and compassionate in their approach. We observed this for most staff when they were interacting with people, but found staff did not consistently treat people with respect and dignity.

Staff were not given appropriate support through regular supervision and appraisal.

Care records we looked at contained some personalised information, but they lacked information about people's lives and achievements and engaging people in these in their daily life at the home.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The systems and processes for the safe storage of medicines was not safe, as refrigerator temperatures were not consistently taken.

People told us they felt 'safe' and relatives supported this. Our findings were that risks presented by people were not adequately managed, meaning they were placed at risk of avoidable harm. Sufficient numbers of staff who were suitably qualified, competent, skilled and experienced were not deployed to meet those risks.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive effective support through regular supervision and appraisal.

The service were working within the principles of the Mental Capacity Act, but were not meeting the conditions of one of the authorisations, which meant the person was not receiving appropriate care to meet their needs.

A varied and nutritious diet that took into account people's dietary needs and preferences, so that their health was promoted and choices could be respected was available. For some people appropriate action following weight loss and risks to people who were at risk of inadequate nutrition were not managed adequately to ensure those people did not continue to be nutritionally compromised.

People had access to a range of health care professionals to help maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives we spoke with told us staff were caring and

compassionate in their approach. We observed this for most staff when they were interacting with people, but found staff did not consistently treat people with respect and dignity.

Is the service responsive?

Inadequate

The service was not consistently responsive.

Care records we looked at contained some personalised information, but they lacked information about people's lives and achievements and engaging people in these in their daily life at the home.

Some activities were provided for people, but a significant amount of these were around group activities.

There was a complaints policy in place, but records were not available for us to assess that complaints were investigated and acted on where necessary.

Is the service well-led?

Inadequate

The service was not well led.

There were quality assurance and audit processes in place, but these had not been effective in ensuring compliance with regulations and identifying areas requiring improvement and acting on them.

The service continued to be in breach of four regulations that had been identified at the last inspection on 30 March and 2 April 2015 and we identified a further three breaches of regulation at this inspection.

Broomcroft House 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 was 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 16 and 21 March 2016 and was unannounced. This meant the provider did not know we were going to carry out an inspection on the day. The inspection on 16 March 2016 was carried out by three adult social care inspectors and a nurse specialist advisor, who specialised in nutrition. The second day of inspection, on 21 March 2016 was carried out by three adult social care inspectors, two of whom had carried out the inspection on the first day.

Before the inspection, the provider 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.

Prior to our inspection, we spoke with 10 stakeholders including the local authority safeguarding team, the local authority contracts team, the local coroner, the South and West Yorkshire Partnership Trust (SWYPT) and Healthwatch Sheffield. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. SWYPT is a specialist NHS Foundation Trust that provides community, mental health, learning disability and health improvement services to people. A stakeholder is a person or organisation who has interest, concern or involvement with an organisation.

The inspection included reviewing information we held about the service. This included correspondence we had received about the service and notifications required to be submitted by the service.

During the inspection we spent periods of time observing care to understand the experience of people who could not talk with us.

During our inspection, we spoke with the manager, a relief home manager, eleven staff members, six people who lived at the home and two relatives of people.

We looked at documents kept by the home including the care records of fifteen people who lived at the home and 19 staff records. We also looked at records relating to the management and monitoring of the home such as training records and quality assurance audits.

Inadequate

Is the service safe?

Our findings

We checked progress the registered provider had made following our inspection on 30 March and 2 April 2015 when we found breaches of regulation in regard to safe care and treatment and staffing.

We checked the systems and processes in place for the safe management of medicines.

Care records we looked at contained care plans for people regarding their medicines. In one care record, we saw that the person required support with taking their medicines and information provided in care plans stated the person liked to take their medicines with water, if they agreed to take them. A best interest meeting had been held regarding this person as they, at times, would refuse to take their medicines. The best interest meeting involved the persons' GP and a family member. A best interest meeting ensures that if a person lacks mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf does so in the person's best interests. The outcome of this best interest meeting stated that, if the person refused their medicines, they could be administered covertly. Covert medication is when medicines are administered in a disguised format such as in food or in a drink, without the knowledge or consent of the person receiving them.

We looked at Medication Administration Records (MAR) and saw that medicines were clearly recorded for each person, including any updates if a new medicine had been prescribed.

Some medicines require special storage conditions, such as in the refrigerator. Such medicines can expire quickly if they are improperly stored at room temperature, becoming toxic or less effective. We saw daily medicines refrigerator temperature checks had not been completed every day, with the last temperature being recorded seven days prior to our inspection. This meant it was not possible to evidence that medicines were being stored safely and correctly. This demonstrated that the home did not manage the safe storage of medicines well or monitor whether storage was suitable.

The above evidence demonstrates a continued breach of Regulation 12 – Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked that sufficient numbers of suitable staff were on duty to keep people safe and meet their needs.

People we spoke with said, "I don't use my buzzer, just wait for them to come, but it could be hours", "I think there's enough staff. I sometimes need help to go to the bathroom and they come" and "I'd be able to get to my buzzer if I needed it, but I don't use it much. I can't say whether they come quickly or not".

A relative told us "Quite often there's not enough staff, particularly at a weekend. There's a lot of agency nurses and they don't know people. That's mainly on a weekend. There's a big turnover of staff". and "I feel [relative's] is safe".

Staff we spoke with said, "I think there's enough staff, particularly as there's less residents at the moment",

"There's usually five care staff on a morning and four care staff on an afternoon, unless someone rings in sick, like today. I don't think there's enough staff to meet people's needs in a timely way. It's always been the case. I think that all staff would agree with that" and "It can be rushed at times. It has been short staffed. BUPA get 'their pound of flesh'".

We saw there were times when one person in particular, who displayed challenging and aggressive behaviours and was a risk to others, was unsupervised and moving around the home. There had been several incidents with this person, most of which had happened when there were no staff around to supervise, monitor the person's behaviours and intervene before others were placed at risk.

Throughout lunchtime, people were sat waiting significant amounts of time until a member of staff either assisted them to eat or removed their food. We also saw people leaving the dining room without desert as they had not being given it in a timely way.

The manager told us that staffing levels at the home were calculated using the registered provider's banding tool. They said, "We're just reviewing it now". They told us the tool was re-assessed each year, but would be done on a monthly basis if needs changed. The banding tool assessed the level of people's needs. However, we found that the banding of people's needs did not always accurately reflect people's actual needs.

We looked at the staffing rota's for the home and found that staffing levels often fell below the required numbers identified by the manager for safe staffing levels due to staff sickness. We found that staff rota's were unclear at times, with two weeks of February's rota's being scribbled through.

The manager and relief manager told us that both unit manager posts were vacant.

The above evidence demonstrates a continued breach of Regulation 18 – Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff personnel files and saw that adequate pre-employment checks were carried out by the registered provider before any staff member started working at the home. These checks included photographic identification, proof of address, reference checks from previous employers and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. Staff personnel files contained a completed application form and interview notes. This meant the home followed safe recruitment practices.

We checked that people were protected from bullying, harassment, avoidable harm or abuse that may breach their human rights.

People we spoke with told us that they felt safe and their relatives or friends supported this.

Staff's understanding of abuse was satisfactory, with all saying they would report any allegations and that they thought and hoped it would be taken seriously.

We had received concerns about the safe care of people, both in terms of people being placed at risk of avoidable harm due to other people's behaviour that challenged and nutrition. Safeguarding alerts had been raised as a consequence of some of these.

Care records we looked at did not demonstrate that people who lived at the home were protected from

abuse and avoidable harm. Risk assessments in place were not always fit for purpose and did not ensure that people were safe. For example, in one care record we saw that the person who lived at the home displayed aggressive, challenging and sexual behaviours because of their condition. These behaviours occurred at any time and were not exclusive to day times. However, risk assessments in place for this person did not adequately address the risks to the person, or to others. Assessments stated that staff should monitor the persons mood and record this on behaviour charts. However, throughout the inspection, there were several times when this person was left with other people who lived at the home, and no staff to monitor the person's mood or behaviours. We also found that the risk assessment was ineffective in practice as incidents involving the person were ongoing.

There were both formal and informal methods used to share information on risks to people's care, treatment and support. We saw daily notes were completed by staff and contained information about what the person had done that day, including their behaviour and mood. However, information contained in daily notes did not always result in risks being managed adequately. For example, we saw in one person's daily notes that they had gone into the sluice room, where the contents posed a risk to them. The incident was dealt with, with instructions to prevent a repeat of any future risks highlighted. We found those instructions had not been followed, with the sluice room left unlocked and on one occasion left slightly ajar. This meant that, although formal and informal methods were used to share information on risks to people, they were not always effective in ensuring that risks were managed.

The above evidence demonstrates a breach of Regulation 13 – Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager if we could see the safeguarding log held at the home. The manager told us that they did not know where the safeguarding log was. This meant we were unable to assess the over-sight of safeguarding concerns and alerts and that safeguarding referrals were monitored and managed adequately.

The above evidence demonstrates a breach of Regulation 17 – Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found assessments had been undertaken to identify some risks to people who used the service. These included environmental risks and other risks due to the health and support needs of the person. For example, some people presented a risk because of their behaviour. We found the risk assessments in place were not always sufficient to protect people and not always followed.

In another example, one person who lived at the home had a PEG (Percutaneous Endoscopic Gastronomy) tube. PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. We looked at this person's care records and found no care plan outlining the care of the PEG, only a leaflet from the PEG nurse outlining trouble shooting. There was a care plan in the person's records for 'food and drink', stating that the person was 'nil by mouth' but nothing about required mouth care. We saw no information about this person's feeding regime, though we did find a letter that stated the person's PEG feed was to be run at 50mls per hour for 20 hours, whilst in an upright position. There had been an incident at the home, where a nurse had given the feed twice as fast as it should have been given, at 100mls per hour, instead of 50mls per hour. This meant the home did not have adequate care plans in place to provide the care and support required for a person who was fed through a PEG tube, to minimise risk and not place people at risk of harm.

This meant risks to people were not being managed effectively so that people were protected and demonstrates a continued breach of Regulation 12 – Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager for the accident and incident log for the home. The manager told us that they did now know where the accident and incident log was. The manager told us that this was due to several other agencies, such as the local authority, having recently been to the home to carry out monitoring visits and records not being put back where they should be.

In the PIR the registered provider had told us improvements they planned to take in the next 12 months to make the service safer in. They had stated 'We also aim to review our accidents and incidents on a quarterly basis from 2015 to look further in to whether there is a time when accidents happen most and how we can overcome this issue'.

This meant we were unable to assess the over-sight of accidents and incidents and that they were monitored and managed adequately.

No lessons had been learnt from the incident where a nurse had given a PEG feed twice as fast as it should have been given, as there were still no care of PEG plan or feeding regime for the person. This meant an effective system was not in place to improve practice and mitigate further risk to people in the monitoring of accidents and incidents.

The above evidence demonstrates a breach of Regulation 17 – Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We checked progress the registered provider had made following our inspection on 30 March and 2 April 2015 when we found breaches of regulation in regard to staffing.

We spoke with staff and looked at training, supervision and appraisal records to confirm that staff were adequately supported to carry out their roles and responsibilities and provide effective care for people.

When we spoke with staff all were consistent in saying they had received an induction on commencement of their employment. Staff told us they found the training useful and said it equipped them for their role. Most staff we spoke with could recall receiving supervision, but not an appraisal.

We looked in staff personnel files and the home's training matrix to see if staff had received training and had regular training updates. We found that most staff were trained in all mandatory areas, and had regular updates, when required. Where staff were due a training update, target dates were recorded for when training should be completed by. This demonstrated that the home ensured training was provided for staff to increase, improve and keep up to date their skills and knowledge. We found some staff had not received the training update by the recorded target date.

Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements.

We checked that staff were receiving supervision. Information in the supervision file stated that staff should receive supervisions every two months. We checked supervision records for 15 staff members. Of these 15 staff members, only five had received supervision in the last two months. Some staff had last received a supervision almost eight months before our inspection. We also saw that, when staff had received supervisions, concerns raised or actions identified were not followed up, or that follow up was not recorded.

Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles. There was no evidence that any staff member had received an annual appraisal.

This meant staff did not have effective support through regular supervisions and appraisals.

The above evidence demonstrates a continued breach of Regulation 18 – Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the systems in place to ensure people were supported to have sufficient to eat, drink and maintain a balanced diet.

People we spoke with said, "Food is really very, very good", "Food's quite good", "Breakfast was nice" and "Food's generally alright".

Relatives we spoke with said, "Meals are very nice. [Relative] always has a good breakfast that's presented nicely" and "We're informed of any concerns with their healthcare. For example, [relative's] blood pressure dropped and the agency nurse called a doctor, who said to check their blood pressure and they increased [relative's] medication".

We carried out observations during lunchtime at the home, to see if people were supported to have enough to eat and drink. We found that people's needs were not always met or respected, and that several interactions took place without staff talking to/interacting with people or explaining what they were doing. For example, the facial expression of one person indicated they did not like the soup they were being assisted to eat as they pulled a face and kept shaking their head. The member of staff continued helping the person to eat it, without asking what was wrong and in fact said, "I told you, you'd like it". The soup was taken away after two spoonfuls. A different staff member attempted to help the same person eat their main meal, which again the person was not acquiescing to, so the staff member went to help someone else. The staff member who had helped the person to eat the soup returned and tried to help with the main meal. After three attempts the member of staff turned to another staff member and said, "Well, we've both tried. I'll try her again later". The person was left with nearly a full plate of dinner in front of them and closed their eyes. The meal was taken away and disgarded. The meal experience was very similar for other people who needed help to eat.

We saw a staff member return from someone's bedroom with a full plate of food and scrape it into the waste bowl. The member of staff said, "She was asleep", meaning the person did not receive their meal. We checked in the waste bowl and saw there was a lot of food that had been scraped from people's plates. We spoke with a member of staff who told us two or three buckets of waste are returned from each floor.

We asked to see the records of food and fluid for people. We were told only people at risk of inadequate nutrition were on those. This did not include the people we had been seen assisted to eat and whose meals had been disgarded. This means there is a risk of those people not being provided with adequate food and fluids, because they had not been identified as at risk.

Throughout the day, we saw that drinks trolleys were brought round in lounges. We saw that several people who were given a drink had it placed on a table that was out of reach. This meant several people did not drink the drinks that they had been given.

The British Association of Dietitians (2013), recommend that adults should drink 1600-2000mls per day. We checked the records of four people's whose fluid intake was being monitored. Those people were receiving fluids in the range of between 100mls – 400mls per day.

We found one person who had repeatedly received low fluid intake had often had urinary tract infections (UTI's), which the person's relative attributed to their relative not receiving enough fluids. We spoke with a nurse about this person. The nurse told us the person was on an antibiotic permanently to prevent UTI's. We found this person had required GP intervention for additional antibiotics three times in a two month period.

In one care record we looked at, we saw a person was at high risk of becoming nutritionally compromised. The person was weighed on admission to the home and a further six times in eight months, at differing frequencies. Each time this person was weighed, they had lost weight but there were several times when no action had been taken or recorded. In the eight months this person had lost almost 20% of their total body weight.

In another care record we looked at, we saw a care plan for eating and drinking. This care plan stated that

the person had no dietary requirements, however, we found documentation stating that the person required a fork-mashable diet. We saw than an evaluation of the care plan that stated the person needed to be weighed weekly. However, the person was not weighed on a weekly basis.

This meant the home had not always taken appropriate action following weight loss and risks to people who were at risk of inadequate nutrition were not managed adequately to ensure people did not continue to be nutritionally compromised.

The above evidence demonstrates a breach of Regulation 14 – Meeting nutritional and hydration needs, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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 application 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 manager told us there were people who had DoL'S authorisations in place. In some records we found there were capacity assessments in place for decisions that deprived a person of their liberty, with relevant care plans in place.

However, for one person we found the person had conditions attached to the application, but these were not all being met. For example, one condition recorded that the person was to spend time outside the care home in activities they enjoyed and staff were to document what was offered. The home's own assessments identified those activities as walking, visiting friends and family, cricket, football and attending church. Discussions with staff and a review of records identified the person was not offered those activities on a regular basis and there was only occasional walks outside the home. The majority of activities recorded or encouraged by staff were activities witin the home.

This meant that whilst authorisations to deprive a person of their liberty were in place when they lacked capacity, the care and treatment provided was not appropriate to meet their needs. This demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person-centred care

The service had not notified the Commission as required by Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009 when people were being deprived of the liberty. This meant the systems and processes in place to report all notifications to the Commission was ineffective in practice and supported a breach of Regulation 17 – Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a training programme in place to prepare staff in understanding the requirements of the MCA and DoLS. When we spoke with staff their understanding of what this meant to

them in practice varied.

We checked that people were supported to maintain good health, had access to healthcare services and received ongoing healthcare support.

Relatives told us that staff would call a GP if their relative became ill.

We saw care records contained details of visiting healthcare professionals that the person had seen and details of those visits. This meant staff involved professionals, so that people received intervention for their healthcare needs to support them to maintain good health and have access to relevant healthcare services.

Requires Improvement

Is the service caring?

Our findings

When we spoke with people and their relatives they said staff were caring. Comments included, "Everything's done for me. They're all very kind", "[Relative's] cared for very well. He needs two staff though and he still understands about his dignity and often he has to wait. I've not been involved in a care planning process. I was once told I had a nurse allocated" and "It's wonderful here. They [the staff] look after me as well. I used to have lunch here, but I don't now. I'm very, very happy. The staff are very, very good".

Throughout the day of our inspection we carried out observations and saw that people were treated with kindness but not always treated with respect and dignity. For example, people who lived at the home were not always well groomed, with some of the men who lived at the home not being clean shaven and the women not having had their hair styled. We observed that staff did not always have time to spend with people and that they were rushed and did not always provide information and explanations that people needed. When staff engaged with people, interactions were mainly for the functional tasks of caring. For example, we saw one person sitting in a chair in the lounge area of the dementia unit. The staff member, who was providing drinks from the drinks trolley saw that this person was asleep but made them a cup of coffee anyway, without asking if that's what they wanted. The staff member then put a straw in the coffee and brought the cup of coffee up to the person's mouth, without telling them they were there. The staff member then put the straw in the person's mouth and told them that they needed to suck the coffee up the straw. We saw the person take a sip from the straw and then the staff member placed the coffee on a table next to the gentleman, just out of reach and said; "Right, I'm off on my break", leaving the gentleman awake and unable to reach his drink.

In contrast we observed some staff interact in a warm and friendly way with people, taking time to speak with them asking if they were comfortable and warm enough.

When staff provided personal care to people, bedroom and bathroom doors were closed to ensure people had their privacy and dignity maintained. We observed a member of staff knock on people's door before entering, explaining what they were going to do.

Staff were able to tell us about people who lived at the home, their likes and dislikes. This demonstrated that staff had information to develop meaningful relationships with people, but they did not always put this into practice.

Care records we looked at did not always contain information about how the person had been involved in their own care planning. This meant the home did not ensure people felt listened to, respected or that their views were acted upon.

An advocate is a person who speaks on someone else's behalf when they are unable to do so for themselves. We saw no information throughout the home about advocacy services that were available. This meant the home did not ensure information was provided for people to understand what advocacy services were and what they could be used for.

This demonstrated a breach of Regulation 10 – Dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no restrictions on visiting times at the home and the manager, staff, relatives and people who used the service confirmed this to us.

A 'Do Not Attempt Cardio Pulmonary Resuscitation' form (DNACPR) is used if cardiac or respiratory arrest is an expected part of the dying process and where CPR would not be successful. Making and recording an advance decision not to attempt CPR helps to ensure that the person dies in a dignified and peaceful manner. In care records we looked at, where required and appropriate, DNACPR forms were in place, where either an advanced decision had been made by the person who lived at the home when they had capacity or by a relevant healthcare professional, if the person lacked capacity to make this decision. DNACPR forms contained information about the person's condition and reasons why CPR would not be attempted. These forms also contained dates the forms were completed and reviewed and had signatures of relevant professionals who had been involved in the decision. This meant the home had arrangements in place to ensure the person who had passed away was cared for and treated in a sensitive way, and in line with recommendations by healthcare professionals or the person themself.

Inadequate

Is the service responsive?

Our findings

We checked progress the registered provider had made following our inspection on 30 March and 2 April 2015 when we found breaches of regulation in regard to person-centred care.

We spoke with people and asked if the staff and service were responsive to their needs. Comments included, "No faults with it. Nowhere is perfect. It's never going to be like home is it? I'd talk to [staff member] if I had a problem", "I can't do much, as I'm almost blind. Family visit and take me home for tea on a Sunday", "If I had a problem I'd firstly talk to staff, but I've no problems. I enjoy reading during the day" and "It's alright. Better than some".

A relative said, "Most of the time [relative's] in his room, but other people walk by the door. The days seem endless for [relative]. They don't read or watch TV. When I come I never see anyone sat with him, talking. It's just when staff come in and out. If I wasn't happy I'd tell one of the nurses" and "I've never had cause to complain".

Care records were lacking in information about people's lives and achievements. For example, in one care record, we saw a document titled "My day, my life, my portrait", which asked what was important to the person, including anything the person was looking forward to or if they had any goals. The answer written by staff at the home stated; "[Person] lives in the present moment now, so these questions are not really applicable." In another part of the same care record, one document asked for the person's hobbies and interests. The answer written by staff at the home stated; "Not relevant nowadays." Another part of the care record asked what the person would like to happen in the future. The answer written by staff at the home stated; "It is not clear whether [person] thinks about the future." This meant information was not available in care records for staff to provide personalised and person-centred care and support, based on the person's likes, dislikes, life history and preferences.

Our observations throughout the day identified not all people were supported to maintain relationships and avoid social isolation.

We saw an activities co-ordinator, who actively involved people in reminiscence and poetry, and 'patting' a dog, which most people enjoyed. We also saw the activity co-ordinator talking with a group of people, telling them stories about themself. The stories were lively and animated and people were listening and engaged. In contrast other people were sat quietly, mainly in lounges, not speaking and not being encouraged to partake in any activities or social interaction.

One person told us they don't get out as much as they would like. A staff member told us this person had gone in the garden with the activity co-ordinator the day before and went on to say "There's not enough staff, but probably everywhere is the same". While we were with this person the activity co-ordinator delivered a paper and it was clear the two knew and liked each other. They spent time together and the activity co-ordinator explained a 'patting' dog was coming later and would take the dog to see them, which they were delighted about.

One member of staff said, "Residents don't do much all day, so they look forward to their food".

Discussions with people, their relatives and staff identified that for some people it was a significant amount of time since they had enjoyed life outside of Broomcroft House.

The above evidence demonstrates a continued breach of Regulation 9 – Person-centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was a complaints leaflet/poster in the reception area of the home so that people knew how to complain, if they needed to. The leaflet detailed how to complain and who people could complain to. We asked for the complaints and compliments file but this was not given to us during our inspection as the manager said they could not find it.

We had received information from one relative informing us of a complaint they had made, alleging BUPA (the registered provider) had taken a while to respond and that they were not sure this was the final response as they had not been provided with the formal complaints policy. Another relative had told us of concerns they had made to the manager, but nothing had been done about it. Because the complaints file could not be made available it was not possible for us to verify that complaints that had been received were investigated and necessary and proportionate action taken in respect to any failure identified by the complaint or investigation. This does not support information provided to the Commission in the service's PIR in how the service dealt with complaints.

This showed an effective system and process was not in place to demonstrate compliance with the regulation receiving and acting on complaints.

We asked for the minutes of meetings that had taken place with people and/or relatives, to check the service had been responsive to people's opinions about the service. Again, we were not provided with this information.

We spoke with a relative who told us meetings for people and their relatives did not take place regularly and that the last one they could remember had taken place six weeks before our inspection.

This showed an effective system and process was not in place to demonstrate the service sought and acted on feedback from relevant people of their experiences of the care provided and evaluating and acting on that experience.

The above evidence demonstrates a continued breach of Regulation 17 – Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We checked progress the registered provider had made following our inspection on 30 March and 2 April 2015 when we found breaches of regulation in regard to good governance.

It is a condition of registration with the Care Quality Commission (CQC) that the home have 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. The previous registered manager had cancelled their registration on 14 October 2015 and the current manager had been managing the home since that date. On the second day of the inspection a relief manager was sent to support the home manager.

There had also been a change in the nominated individual in November 2015. A nominated individual is someone who is employed as a director, manager or secretary of the organisation, responsible for the supervising the management of the carrying on of the regulated activity on behalf of the organisation.

We asked people, their relatives and staff if the service promoted a culture that was open and inclusive, delivered good care and had good leadership and management.

No meaningful information was obtained from people about the management of the service. A relative said, "I've never been introduced to the manager, seen her or spoke with her. They do have meetings every so often. They had one about six weeks ago. My daughter visits and offers opinions".

Staff comments included, "I speak to [the manager] when I need to. She's always approachable. There's usually a staff meeting every two or three months for everyone. We discuss staff concerns and how to work better. We don't get minutes, but a note is put up in the staff room for staff that don't attend. It's not very detailed", "It's a good environment, good place and good atmosphere", "I feel I could go to the manager if needed and that she would take concerns seriously. I wouldn't say regular team meeting, but we do have them. I can't remember when the last one was. I've probably gone to three since I've been here (this would be in about three and a half years)" and "We've had a few staff meetings, but I don't know what's going on at the moment with professionals coming in and when they've been, being given instructions on what we've to do".

All staff said they would not have any reservations for a relative of their own to live at Broomcroft House.

We asked for, but were not provided with minutes of staff meetings.

Throughout the inspection we found our requests for information not responded to, because the manager could not find what we were asking for or they were not easily accessible.

We found that there was a system in place to audit the quality of the service. Audits are one way a service

can check that standards are being maintained. They also identify any areas requiring improvement.

We looked at a sample of audits and found these contained concerns about the service and reflected some of the findings of our inspection. For example, a care plan audit identified twelve care plans had been reviewed. Two of those were identified as a green rating, two at amber and eight at red. Of the eight showing a red rating, the score from two of those identified a score of 50% or below. The rating are based on green (good), amber and red, with red being the worst possible rating.

We saw an audit had been carried out of medicines between 12 and 14 January 2016. This audit showed a score of 30 out of a possible 67, meaning a 'red' rating was given.

We identified that the current audit systems were not robust enough to effectively assess, identify and act upon, risk and improvements required at the service, in order to demonstrate compliance with regulations. For example, ensuring all people received person-centred care that was safe and that their nutritional and hydration needs were met.

Our findings from this inspection identified the governance systems in place to evaluate and improve practice in regard to past breaches of regulation had not consistently been effective.

Since the last inspection on 30 March and 2 April 2015 the service remains in breach of Regulation 9, Person-centred care; Regulation 12, Safe care and treatment; Regulation 17, good governance and Regulation 18, Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found further breaches of; Regulation 10, Dignity and respect; Regulation 13, Safeguarding service users from abuse and improper treatment; Regulation 14, Meeting nutritional and hydration needs and Regulation 16, Receiving and acting on complaints.

We also found omissions in the reporting of incidents to CQC as required by regulations which is a breach of Regulation 17 and 18 of the Care Quality Commission (Registration) Regulations 2009.

On the second day of the inspection the relief manager confirmed that systems and processes had not been in place to effectively monitor and improve the service and mitigate risks relating to the health, safety and welfare of people. She was able to show us how she had begun to address some of those areas, such as setting up quality assurance files to audit the service, monitor incidents and accidents. She told us it was her intention to audit all care files. It is too early to tell whether these will be effective and sustained.

Our findings above mean the systems and processes in place for good governance are ineffective in practice and a breach of Regulation 17 – Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission without delay of incidents which occur whilst services are being provided in the carrying on of a regulated activity or as a consequence of the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Service user's care and treatment was not always appropriate to meet their needs and reflect their preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment had not always been provided in a safe way for service users

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always protected from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of service users were not always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operating effectively to ensure compliance with regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to meet people's needs. Persons employed by the service provider in the provision of the regulated activity had not always received such appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.