Ashberry Healthcare Limited

Broomy Hill Nursing Home

Inspection report

43 Breinton Road
Hereford
Herefordshire
HR4 0JY

Tel: 01432274474
Website: www.ashberry.net

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20 July 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 16 January 2017. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to staff training and supervision, and the provider's quality assurance systems and processes. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements.

Following our inspection on 16 January 2017, we also received concerns in relation to the practice of locking people's bedroom doors at the home throughout the day and night, and how this was being managed. These doors were fitted with specially designed locks that automatically disengaged when opened from within the bedroom itself. We also looked into these concerns during this focused inspection.

This report only covers our findings in relation to these requirements and concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Broomy Hill Nursing Home on our website at www.cqc.org.uk.

This inspection took place on 20 July 2017 and was unannounced.

Broomy Hill Nursing Home provides accommodation with nursing and personal care to a maximum of 40 people living with dementia and mental health needs. There were 36 people living at the home when we visited.

A registered manager was in post and present during our inspection. 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 provider had not delivered training to support staff in carrying out their duties and responsibilities, in accordance with the their mandatory training requirements.

The provider conducted staff supervisions more frequently, and these were now being monitored more closely by the management team. The provider had commenced staff members' annual appraisals.

The provider's quality assurance activities had been developed and a new annual audit planner introduced. However, the provider's quality assurance was not as effective as it needed to be in enabling them to address concerns and shortfalls in quality in a timely manner to drive improvement.

People's rights under the Mental Capacity Act 2005 had not been fully protected in the context of the decisions taken to lock most people's bedroom doors throughout the day and night. Concerns raised with the provider in relation to staff being unable to access, and support people to access, bedrooms without

unnecessary delay had not been satisfactorily addressed.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not delivered training to fully support staff in fulfilling their duties and responsibilities. People's rights under the Mental Capacity Act 2005 had not been fully taken into account or protected.

Is the service well-led?

Requires Improvement

The service as not always well-led.

The provider's quality assurance was not as effective as it needed to be, in enabling them to address concerns and shortfalls in quality in a timely manner and drive improvement.

Broomy Hill Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Broomy Hill Nursing Home on 20 July 2017. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our 16 January 2017 inspection had been made. We also looked into concerns raised since our last inspection. We inspected the service against two of the five questions we ask about services: is the service effective and is the service well-led? This is because the service was not meeting some legal requirements.

The inspection team consisted of one inspector.

As part of our inspection, we looked at the information we held about the service, including the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority and Healthwatch for their views about the service.

During our inspection, we spoke with the registered manager, the provider's director of care and quality, a nurse, a social therapist and three care staff. We looked at four people's care records, staff supervision and training records and records associated with the provider's quality assurance systems.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 16 January 2017, we found that a significant number of staff had yet to complete the provider's mandatory training. Where staff had participated in training, appropriate refresher training had not been consistently organised at the provider's stated intervals. The provider did not have a comprehensive plan in place to address these training requirements. In addition, staff supervision meetings and appraisals had not taken place on a consistent basis for some time. We were not assured that staff had received the consistent training, supervision or appraisals needed to support them in carrying out their duties. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider was still not meeting the requirements of Regulation 18. However, some improvements had been made. For example, over the last six months, the majority of staff had received fire safety training. Smaller numbers of staff had also participated in positive behaviour support, person-centred care and moving and handling training. The registered manager informed us of their intention to organise further training via a new e-learning programme.

However, there were still significant and wide-ranging gaps in staff training. Based upon the provider's mandatory training requirements, no member of staff was fully up-to-date with their training. Further training on safeguarding, infection control and the Mental Capacity Act 2005 was planned through an external training provider. However, the provider still did not have a comprehensive plan in place to address staff training requirements as a whole. The registered manager acknowledged the limited progress made to address the long-term lapse in staff training.

We saw more significant effort had been made to bring staff supervisions up to date. Almost all staff had participated in at least one one-to-one meeting with a supervisor since our last inspection, and a minority of staff had attended an annual appraisal. Although the frequency of staff supervisions had improved, these had not always been organised in line with the provider's procedures. The management team had developed a clear plan for staff supervisions and appraisals moving forward, and maintained up-to-date records to help them keep on top of these.

We were not assured that staff had received the consistent training needed to support them in carrying out their duties. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection on 16 January 2017, concerns had been shared with us about the practice of keeping people's bedroom doors locked throughout the day and night, and how this was being managed. The registered manager explained this long-standing measure had been put in place to prevent certain people from entering others' rooms and causing distress, damage or disruption. People's bedroom doors were fitted with specially designed locks that automatically disengaged when opened from the inside. This allowed people to exit their bedrooms, when they wished, by operating the internal door handle. People may be in their bedrooms, for example sleeping at night, whilst their bedroom door remaining locked from

the outside.

During this inspection, we looked into these concerns. As part of this, we checked whether the decision to lock people's bedrooms doors had been reached in line with the principles of the Mental Capacity Act 2005. 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.

We found no evidence that any mental capacity assessments or best-interest decision-making had been carried out in relation to the decisions taken to lock most people's bedroom doors. When taking these decisions, the management team had not taken into account, or protected, people's legal rights under the MCA. The registered manager acknowledged this issue. They assured us each decision taken to lock a person's bedroom door would be reviewed, as a matter of priority, in line with the principles of the MCA.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 16 January 2017, we found the provider's quality assurance was not as effective as it needed to be. It had not enabled the provider to highlight and address, in a timely manner, the significant shortfalls in quality we identified during our inspection. These included the long-term lapse in staff supervision, appraisal and training. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider was still not meeting the requirements of Regulation 17. The provider had introduced a new annual audit planner to ensure quality audits were carried out at the required intervals. However, the registered manager was unsure about certain aspects of the provider's audit programme, including use of a dignity audit tool, and acknowledged that not all audits were up-to-date. The provider's quality assurance activities had not enabled them to produce a comprehensive plan to address the remaining, significant gaps in staff training.

We looked at the action the provider had taken to address the concerns raised, since our last inspection, regarding the practice of locking people's bedroom doors. These concerns centred upon a staff member having been unable to give a paramedic access to a person's bedroom, as they did not have a master key on their person.

The registered manager informed us all staff had been provided with a master key to people's bedrooms, which they carried with them at all times. However, all of the staff we spoke with indicated there were times when staff forgot to keep their key on their person, and had to locate a key from a colleague. One staff member explained, "Quite often staff don't have a key and have to go around the whole house trying to find one. It happens so often that it's a habit now." We discussed this issue with the registered manager who informed us they were unaware of this problem. They assured us they would review the procedures for issuing staff with master keys, to ensure they were able to access, and support people to access, bedrooms without any unnecessary delay.

We were still not assured that the provider's quality assurance was as effective as it needed to be. It had not enabled the provider to address, in a timely manner, concerns and shortfalls in quality, including the long-term lapse in staff training.

This was a breach of Regulation 17 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes had not enabled them to identify and address significant shortfalls in the quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the necessary training to fulfil their duties.