Care Quality Commission

Mrs Elizabeth Emery

Broadpark House

Inspection report

Belmont Road
Ilfracombe
Devon
EX34 8DR
Tel: 01271 864752

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on 28 August 2015. We returned on 7 September 2015 as arranged with the registered manager.

Broadpark House is registered to provide care and support for up to four people with a learning disability. The registered provider lives in the home and together with her husband, they provide the care. At the time of our visit there were two people living at Broadpark House.

When we visited there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff had not received up to date training specific to people's needs. However, they would contact the relevant professionals if they noticed changes in a person's physical or mental health.

Summary of findings

Staff could not demonstrate an understanding of the Mental Capacity Act (2005). However, they would contact professionals if they were concerned about a person's ability to make decisions. We found the service did not meet the requirements of the Mental Capacity Act (2005).

The service was unique in so far as it was more of a family home. As a result there were no formal systems and processes in place to ensure quality for people. The service ran in an informal way through on-going discussions with people on a constant basis.

People felt safe and staff demonstrated a good understanding of what constituted abuse and how to report if concerns were raised. Measures to manage risk were as least restrictive as possible to protect people's freedom.

Care files were personalised to reflect people's personal preferences. People were supported to maintain a balanced diet, which they enjoyed. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff relationships with people were strong, caring and supportive. Staff were motivated and inspired to offer care that was kind and compassionate.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People said they felt safe and staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised. People's risks were managed well to ensure their safety.

The registered manager and her husband provided people with the support they needed.

The service did not administer any medicines.

Good

Is the service effective?
Some aspects of the service were not effective.

Staff had not received up to date training specific to people's needs. However, they would contact the relevant professionals if they noticed changes in a person's physical or mental health.

Staff could not demonstrate an understanding of the Mental Capacity Act (2005). However, they would contact professionals if they were concerned about a person's ability to make decisions. We found the service did not meet the requirements of the Mental Capacity Act (2005).

People's health needs were managed well.

People were supported to maintain a balanced diet, which they enjoyed.

Requires improvement

Is the service caring?
The service was caring.

People said staff were caring and kind.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

Good

Is the service responsive?
The service was responsive.

Care files were personalised to reflect people's personal preferences.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments through informal discussions.

Good

Is the service well-led?
Some aspects of the service were not well-led.

Requires improvement

Summary of findings

There were no formal systems and processes to ensure quality for people because the service ran in an informal way through on-going discussions with people on a constant basis.

Health and social care professionals spoke positively about how the service was run.

Broadpark House

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 28 August 2015. We returned on 7 September 2015 as arranged with the registered manager.

The inspection team consisted of a lead inspector.

Before the inspection, we reviewed the information we held about the home and notifications we had received. Notifications are forms completed by the organisation about certain events which affect people in their care.

We spoke with two people receiving a service, the registered manager and one member of staff.

We reviewed two people's care files. After our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from a care manager and GP.

Good

Is the service safe?

Our findings

People felt safe and supported by staff. Comments included: “I feel safe living here” and “X (the registered manager) would always help if I was concerned about anything.”

The registered manager demonstrated their safeguarding roles and responsibilities and understood what might constitute abuse. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. However, there was no policy in place for them to refer to. There had been no safeguarding concerns for several years.

People’s individual risks were identified and the necessary risk assessment reviews were carried out to keep people safe. For example, risk assessments for falls and self-neglect. In addition, risks were managed on an on-going basis when people were accessing the local community alone. Risk management considered people’s physical and mental health needs and showed that measures to manage risk were as least restrictive as possible.

The registered manager and her husband provided the support for people. People felt their needs were met in a timely way. Comments included: “If I was worried in the night, I would get X (registered manager) or her husband. I never worry” and “We are never left in the house alone.” Staff sickness was managed between the registered manager and her husband. The registered manager’s daughter was also available if needed, who had the appropriate checks in place to ensure she was safe working with vulnerable people.

As the service did not employ any other staff, there were no recruitment and selection processes in place. Both the registered manager and her husband had Disclosure and Barring Service (DBS) checks in place.

The service did not administer any medicines. People’s medicines were self-managed and they attended GP appointments according to their assessed needs and prescribed treatment. One person commented: “I manage my own medicines.”

Requires improvement

Is the service effective?

Our findings

Both the registered manager and her husband had not received up to date training on subjects specific to people's needs. For example, safeguarding vulnerable adults and the Mental Capacity Act (2005). However, the registered manager had a wealth of experience supporting people in care settings. When asked about keeping up to date with best practice, the registered manager said they would contact the relevant professionals if they noticed a change in a person's physical or mental health.

People had capacity to make decisions about their care and treatment. Staff could not demonstrate an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, they did understand they would need to contact professionals if they noticed changes in a person's ability to make decisions. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. No one was subject to DoLS and were free to leave the home when they wanted, whether alone or with support.

People did not comment on whether staff were well trained, however felt their individual needs were met.

Staff knew how to respond to specific health and social care needs. For example, recognising changes in a person's physical or mental health. Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. For example, how people preferred to be supported when anxious.

People confirmed they were supported to see appropriate health and social care professionals when they needed, to meet their healthcare needs. One person commented: "If I was poorly X (the registered manager) or X (husband) would call the doctor." There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. For example, their GP. Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion.

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People's individual wishes were acted upon, such as how they wanted to spend their time.

People were supported to maintain a balanced diet. Comments included: "X (the registered manager) always says, never go hungry"; "The food is excellent here. Always snacks available" and "I make my own drinks." Staff knew if there were changes in a person's nutritional intake they would need to consult with the relevant health professionals involved in their care.

Good

Is the service caring?

Our findings

People felt cared for by staff. Comments included: “X (the registered manager) and her husband are very caring. Lovely people” and “I have lived here for years and love it.”

People felt they were treated with dignity and respect when being supported with daily living tasks. A comment included: “My privacy is always respected and have my own personal room.” Staff told us how they maintained people’s privacy and dignity. For example, ensuring the bathroom door is closed whilst a person has a bath.

Staff adopted a positive approach in the way they involved people and respected their independence. For example, encouraging people to access the local community and socialise with people. Comments included: “I am encouraged to be as independent as possible” and “I often go out on my own in Ilfracombe.” Staff recognised how important it was for people to be in control of their lives to aid their well-being. For example, ensuring people had access to as many opportunities as possible.

Staff supported people in an empathic way. They demonstrated this empathy in their conversations with people they cared for and in their discussions with us about people. Staff showed an understanding of the need to encourage people to be involved in their care. For example, encouraging people to maintain their personal care and attend appointments with their GPs.

Staff relationships with people were strong, caring and supportive. People commented: “X (the registered manager) and her husband really care about me and offer support when I need it” and “We are a family and this is home.” Staff spoke confidently about people’s specific needs and how they liked to be supported. Staff were motivated and inspired to offer care that was kind and compassionate. For example, staff demonstrated how they were observant to people’s changing moods and responded appropriately. For example, when a person was feeling upset. They explained the importance of supporting them in a caring and calm manner by talking with them about things which interested them and made them happy. This showed that staff recognised effective communication to be an important way of supporting people, to aid their general wellbeing.

Staff adopted a strong and visible personalised approach in how they worked with people. There was evidence of commitment to working in partnership with people in imaginative ways, which meant that people felt consulted, empowered, listened to and valued. Staff spoke of the importance of empowering people to be involved in their day to day lives. They explained that it was important that people were at the heart of planning their care and support needs. People confirmed they were treated as individuals when care and support was being planned and reviewed.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved. People's comments included: "I am fully involved in my care" and "I help with the chickens. I love doing that."

People were involved in making decisions about their care and treatment through their discussions with staff. Care files were personalised and reflected the service's values that people should be at the heart of planning their care and support needs. For example, people said they were encouraged and supported by staff to identify specific goals they wanted to achieve. They felt this aided their sense of purpose and value.

Care files included personal information and identified the relevant people involved in people's care, such as their GP. They included information about people's history, which provided a timeline of significant events which had impacted on them, such as, their physical and mental health. People's likes and dislikes were taken into account in care plans. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support.

Care plans were clearly laid out. They were broken down into separate sections, making it easier to find relevant information, for example, physical and mental health needs, medicines and skin care. Relevant assessments were completed, such as continence management.

People engaged in a variety of activities within the home, such as watching TV and attending to the chickens and in the local community going to specific places of interest. Staff commented: "It's about promoting independence" and "Important to promote life fulfilment."

There were regular opportunities for people to raise issues, concerns and compliments. This was through on-going discussions with them by the registered manager. There was an outdated complaints procedure displayed in the kitchen, which did not have the correct details if a person wanted to escalate a complaint. However, people confirmed that they would not hesitate to speak to the registered manager if they had any concerns.

Requires improvement

Is the service well-led?

Our findings

There were no policies and procedures available for us to view during our inspection. For example, a policy on safeguarding vulnerable adults. We also found that the home did not have a Mental Capacity Act (2005) policy in place to provide the legal framework to work within to ensure the protection of people in their care. However, the registered manager knew to contact relevant professionals if any concerns became evident which impacted on people.

The service was unique in so far as it was more of a family home. As a result there were no formal systems and processes in place to ensure quality for people. The service ran in an informal way through on-going discussions with people on a constant basis.

The registered manager recognised how input from health and social care professionals on a regular basis was important to ensure people received the right care and treatment. We contacted professionals to seek their views of Broadpark House.

A care manager had only visited Broadpark House on one occasion. However they found the registered manager to be very approachable and very helpful. Adding they were open and honest about their intention not to take on any more people as they were hoping to retire eventually. They felt people were treated as one of the family and people had no concerns or worries about staying at Broadpark House. The house looked in very good condition and felt like a home from home.

A GP commented: “The service is great. The registered manager is caring, competent and proactive. Always acted on advice and doctor’s instructions. She would also keep me updated. I have no concerns about how the service is run.”