Broadoak Group of Care Homes

Broadoak Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook this focused inspection on 16 November 2017. This inspection was partly prompted by an incident which had a serious impact on a person that indicated potential concerns about the management of risk in the service. Shortly after our inspection visit we were made aware of another serious incident. The investigation into this is on-going.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Broadoak Lodge on our website at www.cqc.org.uk.

We carried out this focused inspection on 16 November 2017 and the inspection was unannounced. Broadoak Lodge is a care home without nursing and provides care and support for up to 27 older people including people living with dementia. At the time of the inspection there were 25 people using the service.

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.

There were not always sufficient numbers of staff to meet people's needs or to keep them safe.

Staff knew how to recognise the signs of abuse and what action to take should they suspect it. However, the registered manager failed to report a serious allegation to the local authority safeguarding team or to the CQC. This meant that people may not always be protected from abuse.

People told us they received their medicines in the right way and at the right time. We saw that staff followed correct procedures for the safe administration of medicines. However, where medicines were prescribed on an as required basis, there was insufficient instruction to staff about when this medicine should be given. This meant there was a risk of inconsistency as to the amounts of medicines given.

Risks were assessed and management plans were in place to reduce the risk. For example, some people had a pressure mat that alerted staff when they stood up if there was a risk they would fall. However, because staffing levels were not always sufficient to meet people's needs there was a risk there may not be enough staff to respond to the pressure mat alarm. In particular there were instances of only two staff members being on duty at night. If both of these staff members were attended to a person that required two staff to help them mobilise then there were no staff available to respond to or monitor other people's needs.

Daily health and safety checks were carried out on the premises and environment. Routine maintenance and safety checks were also carried out such as checking hoists and electrical and gas appliances were safe to use. However, routine maintenance work on the hot and cold water systems had not been carried out since January 2017 despite the providers own policy stating this should be done every two weeks. Staff had

not had a fire drill since our last inspection.

Quality monitoring did not effectively identify issues or lead to improvements. People and staff felt supported by the registered manager and felt they were approachable and accessible. We identified that improvements were required at our comprehensive inspection in April 2017 but action had not been taken to improve.

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 safe?

Requires Improvement

The service was not consistently safe.

There were not always sufficient numbers of staff on duty to meet people's needs and keep them safe.

People may not be protected from abuse because national and local safeguarding policies and procedures were not always followed.

There were no Instructions for staff about administering medicines that were prescribed 'only when required'.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality of the service was not effectively monitored and issues were not always identified or acted upon.

The providers policies and procedures were not always being followed by staff.

People and staff felt the registered manager was supportive and accessible.

Broadoak Lodge

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 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.

We undertook an unannounced focused inspection of Broadoak Lodge on 16 November 2017. This inspection was partly prompted by an incident which had a serious impact on a person that indicated potential concerns about the management of risk in the service. Shortly after our inspection visit we were made aware of another serious incident. The investigation into this is on-going.

The inspection was carried out by one inspector. Before the inspection we reviewed information that we held about the service such as notifications, which are events which happened in the service the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider.

During this inspection we spoke with four people using the service and three of their relatives. We also spoke with the registered manager and four care staff.

We reviewed the records and charts relating to five people and two staff recruitment records. We looked at other information relating to the running of and the quality of the service. This included quality assurance audits, medicine administration records, staff duty rotas and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 13 April 2017 we found that improvements were required because some people said there were not always enough staff on duty to meet their needs and people had to wait for staff to attend to them. We made a recommendation that the service reviews arrangements for assessing and monitoring staffing levels to make sure they are flexible and sufficient to meet people's individual needs.

At this inspection we found that the service had not taken action to improve. The registered manager told us they calculated the numbers of staff required based on people's needs. However, there was no recorded evidence of this or of any staffing tool being used. There were 25 people using the service at the time of this inspection and we were told that there should be four care staff on duty during the day and three at night. When we looked at the staffing rota we saw that on five occasions in November there were only two staff on duty when there should have been three. On one of these nights a person who used the service left the building unaccompanied and became lost. The staff contacted the police and the person was returned by a member of the public.

One person had been assessed as requiring additional assistance between 4 and 8 pm. This person required a member of staff to be available to them to keep them safe. There were no additional staff provided for this person. The registered manager told us that one of the existing four staff members was assigned to assist this person but they would also be responsible for carrying out other duties and supporting other people. Records showed that this person continued to display behaviour that may put them at risk on most days and nights.

Staff told us and records showed that at least four people had high dependency needs and required close observation to keep them safe and at least two staff to attend to them when assisting with mobility and personal care. This meant that if staff were busy assisting these people they were not available to attend to other people's needs or to keep them safe particularly at night when there were only three and at times two staff on duty. Some staff felt there were enough staff on duty to meet people's needs while others said there were not and that this made them dread coming to work. Staff said that when other staff rang in sick with short notice then this left them short of staff.

People and relatives also told us there were not always enough staff on duty to meet people's needs. One person said, "You have to wait [for staff] a lot." One relative told us that there had not been any staff in the lounge for more than 10 minutes on one afternoon. Some people were at risk of falling or hurting themselves or others and should not be left unsupervised in communal areas. For example, during our inspection we witnessed a person pulling a walking frame which was under another person's legs and this could have resulted in an injury if we had not intervened. Two other visitors to the service told us it was not unusual for people to be waiting for up to 30 minutes for staff to take people to the toilet.

Since our last inspection on 13 April 2017 there had been between three and five falls each month some of which had resulted in serious injury. While we could not link any of these falls directly to avoidable harm or insufficient numbers of staff we could not be sure that this was not a factor. There was no evidence of

reviewing or investigating accidents and incidents or identifying trends so that lessons could be learned.

These matters were a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

At our last inspection on 1 April 2017 we found that improvements were needed because two people expressed concern about the attitude of some staff members. We discussed this with the registered manager who took immediate action. The registered manager alerted the local authority safeguarding team and commenced an investigation. Shortly after our visit we were informed that the registered manager and a manager from a different service had spoken with the people concerned. The outcome of the investigation was inconclusive and both people said they were happy with the way staff supported them.

At this inspection people said they liked the staff and felt safe. Staff we spoke with knew how to recognise the signs of abuse and what action to take should they suspect abuse. This included reporting any concerns to the local authority safeguarding team. However, shortly after our inspection a serious allegation of abuse was made. This was investigated by the provider but not reported to the local authority safeguarding team, to the police for to the CQC. The registered manager did not follow the correct procedure for this and said they had been advised not to report the concern by a manager from another of the provider's services.

These matters were a breach of Regulation 13 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse.

People told us they received their medicines in the right way and at the right time. We saw staff administering people's medicine's at lunchtime. The staff member wore a red tabard which reminded people not to disturb or distract them from this activity. The staff member followed the correct procedure for the safe administration of medicines. They made sure people had taken their medicines and offered assistance where this was required. Staff had received training about managing people's medicines in a safe way and had their competency to do so assessed. Records of medicines received into the service, administered and returned to pharmacy were maintained. This meant that staff could check that correct procedures were being followed and people had received the right amount of medicine as prescribed by their doctor. Medicines were stored securely and in line with manufacturer's requirements.

Some people were prescribed medicines on an 'as required basis' this meant that staff had to make an assessment as to if and when this medicine was required. Written protocols should be in place when medicines are prescribed on an 'as required basis' to ensure that they are given in the circumstances required by the doctor. For example one person was prescribed a medicine to help with their anxiety. There was no protocol in place for this and this meant that staff had to make an assessment as to when it should be given. Because there was no protocol then the medicine may have been given in an inconsistent way. This was discussed with the registered manager who agreed to ensure that all 'as required' medicines had a protocol that staff could follow.

Risk was assessed and recorded along with management plans so that's staff could take action to reduce the risk of harm. For example, one person at risk of falling when in their room had been provided with a pressure mat that alerted staff when they stood up. Staff we spoke with were able to describe the correct action to take in the event of an accident. A care staff member told us they would always call an ambulance for any un-witnessed fall and would check people for pain and injury.

Records showed that routine maintenance and safety checks had been carried out for the premises and equipment. For example, fire safety equipment was checked to ensure it was in working order. Daily health

and safety checks were carried out to ensure the environment was free from hazards. Hot water temperatures were checked and recorded as being delivered within safe limits. Staff had received training about fire safety but there had not been any fire drills held since our last inspection. The registered manager was made aware of this and told us they would take action to address this.

People said they were happy with the cleanliness of the service. We saw that 'cleanliness and tidiness' were part of the daily checks carried out by the registered manager or senior carer. There was an infection control policy for staff to follow. Staff understood this and were aware of the requirement to use protective equipment such as gloves and aprons and how to safely dispose of waste. The registered manager told us they had recently attended infection control training and planned to implement the guidance about setting and measuring performance outcomes against the national specifications for cleanliness.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was included on the rota to provide direct care and did not have any protected hours to carry out management responsibilities. We were concerned they did not have enough time to complete their managerial work but were told that this was completed in the afternoons and evenings. However, apart from daily health and safety checks of the premises and the environment, there was no evidence of further review of the delivery of care, treatment and support against current guidance. The service had not taken action to improve staffing concerns identified at our last inspection in April 2017. Systems had failed to identify on-going staff shortages and the impact and risk this had on people and on staff. This included a person leaving the service unaccompanied and getting lost and people having to wait for staff to attend to them. There had not been a fire drill held since our last inspection. Processes and checks for the management of hot and cold water systems to reduce the risk of legionella had not been carried out since January 2017; this is despite the providers own policy stating that this should be carried out weekly.

The registered manager had failed to notify the local authority safeguarding team or the CQC about a serious allegation and had been given advice from another of the providers managers that notification was not required. This is contrary to local and national safeguarding policies and procedures and the providers own safeguarding policy.

People, visitors and staff said the registered manager was approachable and supportive. Some people did not feel that the registered provider always took the action required to support and improve the service. For example some people and staff felt that the décor would benefit from updating but this had not been addressed. At our last inspection in April 2017 the provider told us they had arranged for the outside areas to be tidied up and new plants and artificial grass to be fitted. We could not see any evidence of this work being carried out.

These matters were a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Meetings were held for people and for staff so that changes could be communicated and people could provide their feedback about their experiences. One person said "They will listen and make changes." A staff meeting took place on the day of our inspection and we heard the manager give staff opportunities to have their say. We also looked at the minutes of previous staff meetings and saw that staff had been reminded to always speak with people in a respectful way. Staff were also asked to let the service know as soon as possible when they could not make their shift because of illness or other reasons so that they had more time to arrange cover.

Minutes of the resident's meeting held in July 2017 recorded that people had asked to go out on a trip to Rutland water and to a garden centre. This had not yet been arranged; the registered manager said they would look into this. Annual satisfaction surveys were sent out to people who used the service and their relatives. The registered manager told us they were in the process of sending these out at the time of our

inspection.

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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People may not be protected from abuse because staff did not always follow local and national guidance about reporting suspected abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring did not effectively identify concerns or make changes to improve,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff on duty to meet people's needs or keep them safe.