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

Overall summary

We carried out an unannounced inspection of the service 18 March 2015.

Broadoak Lodge provides accommodation for up to 27 people who require personal care. On the day of our inspection 26 people were using the service.

There was a registered manager employed at the service but at the time of our visit they had relinquished their management responsibilities and were working as a member of the care team. 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.

During our last inspection 25 September 2014 we asked the provider to take action to make improvements to protect people living at the service. The provider was not meeting three Regulations of the Health and Social Care Act 2008. These were in relation to people's care and welfare, staffing and assessing and monitoring the quality of care provision. The provider sent us an action plan to tell us the improvements they were going to make. During this inspection we found there were continuing breaches to these regulations.

Summary of findings

People told us that they felt safe living at Broadoak Lodge. At the time of our inspection there was an active safeguarding investigation into a high number of pressure sores. Six people had developed pressure sores in the last six months. We found there were gaps in recording about when people had their position changed to reduce risk. Risk management plans were not always effective and some people were not properly protected.

People and their relatives told us that staff were very busy. Low staffing levels had resulted in one person falling at night because the two staff on duty were busy attending to another person. Staffing levels were decided by the provider but they were not based on the needs of people who used the service.

People told us they received their medicines at the right time and as prescribed by the doctor. There were some recording inaccuracies and insufficient guidance for staff about 'as required' medicines and when these should be given.

People mostly said that staff were trained and knew how to meet people's needs. Not all staff had received the training they required and we were given examples of how people with dementia did not always have their needs met.

Verbal consent was gained before staff carried out any care and support and staff were clear about promoting people's choice and autonomy. We saw mental capacity assessments had been completed for some people who lacked mental capacity to make decisions about their care and treatment. However these were not decision specific and therefore did not fully meet the requirements of the MCA legislation.

People told us they liked the meals provided. Risk of malnutrition was assessed and action was taken to reduce the risk. Records for fluid intake were maintained but sufficient action was not taken when daily fluid intakes were low. People had access to healthcare professionals when this was required. For example people were referred to dieticians, community nurses and mental health teams.

Interactions between staff and people who used the service were positive and respectful. However, some of the language staff had used in daily records was not respectful and showed that some staff did not fully understand people's need. Five people had dirty fingernails and relatives told us that at times they found their relatives clothes were food stained. Two people told us they did not have as many baths or showers as they would like. Records showed that some people had very few baths or showers in the previous three months.

Care plans were not personalised and did not include people's preferred way of receiving care. People were not involved in the care planning and review process. There were very limited opportunities for people to pursue their hobbies and interests or engage in any activity.

People told us they could make a complaint and would feel comfortable doing so. Two relatives were unsure about who was managing the service. Not all complaints were recorded and complaints were not used as an opportunity for learning and improvement.

The provider's action plan to address the breaches to regulation found at our inspection in September 2014 stated that actions would be completed by January 2015. During this inspection we found that this action had not been taken. There was not an effective system in place to measure and review the quality of care. Satisfaction questionnaires were given to people who used the service and their relatives. This was last done in December 2014. There were 11 questionnaires returned. The majority of comments were positive but a lack of activities and not enough staff had been identified by one person's relative. During our inspection we found that some radiators were very hot to touch. There was no risk assessment in place or action taken to reduce the risk.

Staff told us that their manager was approachable and would listen to them. However there had been a lack of consistency caused by frequent changes in the management arrangements at the service in the previous 12 months.

We found two breaches of the Health and Social Care Act 2008 Regulations during this inspection. You can see the action we have told the provider to take at the end of this report.

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 not safe.

There were not enough staff to keep people safe and meet people's individual needs.

People were not always protected from the risks associated with receiving care.

Overall, we found there were appropriate arrangements for the safe handling of medicines.

Inadequate

Is the service effective?
The service was not effective.

Staff had not received all the training they required to meet people's needs.

We saw mental capacity assessments had been completed for some people who lacked mental capacity to make decisions about their care and treatment; however these were not decision specific and therefore did not fully meet the requirements of the MCA legislation.

The quality of food and choice of meals was good.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People told us they liked the staff and had positive relationships with them.

Dignity was not always maintained because some were not as clean as they should be.

The language used to describe care and support was not always respectful and showed that staff did not always understand people's needs or communication difficulties.

Requires Improvement

Is the service responsive?
The service was not responsive.

People did not receive consistent personalised care. Opportunities for people to follow their hobbies and interests were limited.

Complaints were not used as an opportunity for learning and improvement.

Requires Improvement

Is the service well-led?
The service was not well led.

There was a lack of consistency and direction of leadership.

Requires Improvement

Summary of findings

The providers systems for monitoring the service were not effective and did not properly manage risk.	

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 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 inspection took place 18 March 2015 and was unannounced.

The inspection team consisted of two inspectors.

On the day of the inspection we spoke with four people who used the service and five relatives for their experience of the service. We also spoke with the acting manager, three care staff and the cook.

We looked at the care records of six people along with other records relevant to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience

of people who could not talk with us.

We spoke with a community nurse and to a care commissioner and asked for their views about the service.

Is the service safe?

Our findings

At our last inspection we identified some concerns with staffing because there were not always enough qualified, skilled and experienced staff to meet people's needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found that there were continuing problems with people having to wait for staff to attend to them and of people not having their needs met.

One person told us they frequently had to wait for staff to attend to them. This person had fallen on three occasions. They said that on more than one occasion they did not get to the toilet in time. They frequently had to wait for staff to attend to them when they wanted to go to bed and had to go to bed much later than they preferred. They also told us they wanted to have a shower at least once a week but staff were often too busy to meet this need. A relative told us their relative did not have a bath or shower when they needed one. This person was entirely dependent on staff to meet their personal hygiene needs. Their relative told us they had found their relative had been incontinent yet had to wait for staff to attend because they were busy. Records showed that this person had only had five showers in an 11 week period. Records showed that many people were not receiving showers for more than a week at a time.

One person said there were enough staff on duty and they did not have to wait, another person said “When they are busy the staff are run off their feet”.

We were informed by the acting manager that five care staff were on duty during daytime hours and two members of staff were on duty at night. We asked staff about people’s needs and dependency levels. We were told that there were six people who required two staff to attend to them when transferring in a hoist and for positional changes. Two other service users were on 15 minute observations because they were at risk of falling when trying to get up without the assistance of staff. When there were only two staff on duty, if those two staff were busy attending to the needs of one person then there was no other member of staff available to meet the needs of others. An example of the impact of this was seen in records where night staff had recorded they heard a person shouting for help because they had fallen but could not quickly respond because they were attending to another person.

A relative told us that on one occasion there were only three members of staff on duty during part of the day and only two on another day. We had no way of checking this because the duty roster did not record actual staffing numbers or where staff had taken on additional shifts. Staff told us that weekend shifts could often be short of staff because of late notice staff absences. We asked the acting manager about how staffing levels were decided and how they ensured that staffing levels met people’s needs. We were informed that the decision was made by the provider in conjunction with the manager but there was no staffing formula or dependency based tool used. We could not be assured that staffing numbers were sufficient to meet the needs of people who used the service.

Risk was assessed and management plans were in place. For, example people had their risk of falling and of malnutrition assessed. Management plans were not always effective and some people were not properly protected.

At the time of our inspection there was an on-going local authority safeguarding investigation into the number and severity of pressure sores sustained by service users at the service. We spoke with a community nurse who informed us that there had been six service users who had developed pressure sores on their heels in the last six month period. People assessed as at risk of developing pressure sores or who had pressure sores had positional change charts in place for staff to record when they changed the person’s position. We found that there were gaps in the recording on three people’s charts. When we looked at archived records we saw there were recording gaps on most of the charts we looked at. This meant that there was a risk that people had not received the care that they needed to avoid the risks associated with pressure sores. It also meant that the provider could not assure themselves that people were receiving the care that they needed in this important area of their health and welfare.

The community nurse also told us that the new acting manager was proactive and made appropriate referrals. For

Is the service safe?

example, they had asked the community nursing team to assess a person for the use of bedrails because they had fallen. They said that the service had improved over the previous three weeks because of the new acting manager.

These matters were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and that staff would take action if they had any concerns. One person said, "Yes the staff are good, they come when you want and they listen." Staff knew how to recognise the signs of abuse and who to report it to. Telephone numbers of other authorities to contact in the event of suspected abuse were available to staff.

Staff maintained records of accidents and incidents. These were audited weekly by a senior carer. Audit records did not properly analyse accidents and incidents and there was limited evidence of staff taking action to reduce further risk. The acting manager told us about action they had taken in response to one person having falls at night. They had contacted a community nurse and asked for an assessment.

Radiators in the lounge, corridors and some people's bedrooms were very hot to touch and painfully hot to hold. This presented a risk to people who used the service, particularly those at risk of falling and those who would have been unable to either recognise or respond to the danger. We asked the acting manager how this risk was managed. They told us this risk had not been identified or assessed. They told us they would take immediate action about this.

People told us they received their medicines and at the right time. One person said, "Yes definitely and they [staff] make sure I take them when I go out". We observed staff administering medicines and saw that they assisted people appropriately and gave people the time they needed. Whilst medicine administration records were mostly accurate and up to date, we did see that there were some gaps in these records. For example, a person's medicine had been signed as given each day but it was prescribed to be given once a week. We checked the remaining stock of this medicine and saw that it had been administered as prescribed but staff had signed the records inaccurately. Protocols were not always in place for medicines that were prescribed on an as required basis. This meant that staff did not have enough guidance about when to administer the medicine.

The use of as required medicines was not addressed in the provider's medicine policy nor was the management of prescribed creams. We saw that some creams had been signed for but others were not. We were told that action had been taken about this and separate recording charts had been requested so that the one for creams could be more accessible to staff. Medicines were stored in a secure way and in line with manufacturer's requirements. For example, some medicines had to be stored in a fridge. Staff checked fridge temperatures daily to ensure the medicines were stored safely.

Staff responsible for managing people's medicines had received training but they had not had their competency assessed. The acting manage told us they planned to introduce competency checks.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that staff were trained and knew how to meet people's needs. One relative said staff would benefit from more training about dementia because they did not always understand what people needed. They said that staff did not often spend time sitting down and chatting to people.

Staff told us about the training and support they received. They told us that training about dementia was booked for all staff. There was also a list of forthcoming training and this included fire safety, tissue viability and moving and handling.. Records showed that some staff had not received all the training they required or were overdue an update or refresher. The provider's records stated that 58 percent of staff had up to date training about safe moving and handling, and 48 percent had received training about dementia and 76percent had up to date training about fire safety. This meant that people may not receive effective care because staff did not have up to date training. .

Staff received induction training when they first began working at the service. Records showed that a first day induction and induction checklist was being used. Induction training was not comprehensive or based on any recognised guidance. The acting manager told us they planned to introduce common induction standards from April 2015. Common induction standards promote sector specific best practice care delivery.

A relative told us their relative had difficulty with verbal communication because of dementia. They told us that staff offered their relative a choice of tea or coffee. Their relative usually replied coffee because this was the last word they heard the staff member say. The person did not in fact like coffee and their care records stated that they preferred tea. This demonstrated that staff were not communicating with this person in effective way. There was no use of pictorial aids or other adaptations to assist people with communication difficulties.

Staff received supervisions with their line manager. This meant they had opportunities to discuss training and development needs or raise any concerns. We saw that the new acting manager had changed the supervision record template so that staff supervision was more in-depth.

Our observations showed that staff gave people choices and obtained people's consent before providing care and support. People told us that they were asked for their consent. Care plans contained a section for people to give their consent to receiving ongoing care. Three of the four care plans we looked were not signed by the person who used the service or their relatives.

The Mental Capacity Act 2005 (MCA) is legislation that protects people who do not have mental capacity to make a specific decision themselves. Staff demonstrated that they gained people's consent and involved people as fully as possible in day to day decisions. We saw mental capacity assessments had been completed for some people who lacked mental capacity to make decisions about their care and treatment; however these were not decision specific and therefore did not fully meet the requirements of the MCA legislation.

Two people had a deprivation of liberty authorisation in place. Deprivation of Liberty Safeguards (DoLS) protects people where their liberty to undertake specific activities is restricted. The acting manager told us they were in the process of making further applications to the supervisory body that had responsibility for assessing if authorisations to restrict people were necessary.

People told us they liked the meals provided. One person said, "The food is very good, we have lovely puddings". A relative said their relative can't wait to get to the table. "They're [staff] good about changing things and offering alternatives, they take the food to the room when they are not well. They make a mean trifle. The options are good and there is always enough."

At lunchtime people were offered verbal choices of food and staff waited for an answer. The menu was displayed on a chalk board in the dining room but was difficult to read. No other formats were available to support people with communication needs. We observed a person that did not want either of the meal choices and was offered a further alternative which they accepted. The lunchtime meal was nicely presented and staff assisted people where this was required. We saw that one person had refused to eat their meal. A staff member asked that fortified cereal be offered. This was done and the person ate it all.

There was a four weekly menu and people were asked about their meal choice. People's dietary needs were

Requires Improvement

Is the service effective?

recorded in care plans and there was a list in the kitchen. Fridges freezers and pantries were well stocked. Fresh fruit and vegetables, cheese, cream and whole milk were available.

People had their risk of malnutrition assessed and action was taken where risks was identified People had been referred to a dietician and records of food and fluid intakes were maintained where this was required. The care plan for one person who required staff to monitor their fluid intake did not specify the optimum daily fluid intake for this person. Fluid charts recorded daily intakes of between 600 mls and 1800 mls. There was no record of any action taken when fluid intake was low.

People told us they had good access to healthcare services. They said that staff would contact their doctor or community nurse as soon as this was required. Records showed that people were referred to dieticians, speech and language therapists and community mental health teams.

Requires Improvement

Is the service caring?

Our findings

People told us they liked the staff and had positive relationships with them. One person said, "I like it here the carers are very kind to me." One member of the care staff was singled out and praised by a person who used the service and a visiting healthcare professional. A person said, "I would hate it if they left, they sort things out straight away. Another person told us that most staff were kind but there were not enough staff.

Our observations showed that staff mostly interacted with people in a positive and respectful way. During lunchtime staff assisted people where this was required. Some staff said very little when assisting people while others engaged the person in conversation and extended the conversation to others at the table. Two people appeared to need aids and adaptations to assist them to eat more comfortably but these were not provided. One person would have benefitted from a plate guard. Another person sitting in a wheelchair struggled to get the food to their mouth due to the distance from the table. One person started to feed themselves the main course. A staff member sat beside them and fed them their meal. Another person had been fed their main course. Their pudding was brought to them and they picked up their spoon and helped themselves to their pudding. This showed that some staff did not fully promote people's independence.

Some people said they did not like it in the communal lounge because some people were shouting. This was in reference to people who shouted out because of their dementia or mental health needs. One person required a member of staff with them at all times in order to keep them safe and meet their needs. We saw that this staff member stayed with the person and offered reassurance. However, we did not see any attempts to engage the person in activities which may have occupied and distracted the person.

At our last inspection in September 2014 we found that the language used by some staff in records was disrespectful. At this inspection we found that this was still the case. For example, staff had written 'A very difficult night with (name of person who used the service)', kept buzzing asking for trivial things and constantly on the buzzer.' This type of language demonstrated a lack of respect and a lack of understanding for the needs of people who used the service.

People told us they had not been involved in developing their care plan and were not involved in the review process. We were informed that there had not been a resident's meeting in the last three months. People were not actively involved in decision making about their care and support. One person had an advocate appointed. This is an independent person who can speak up on the person's behalf.

When asked if staff respected privacy and dignity, one person said "Yes they do, they are very good." Another person told us that staff always knocked on their door before entering. Relatives confirmed that this was the case. Some relatives were concerned that at times people had dirty fingernails, food on their clothing and sometimes an unpleasant odour. This did not uphold people's dignity.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we identified some concerns with care and welfare because care and support was not always planned and delivered in a way that was intended to ensure people's safety and welfare or meet individual need. This was a breach of Regulation 9 of the Health and Social Care Act 2008, which following the legislative changes of 1st April 2015 corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection one person told us they did have their individual needs met. People had their needs assessed before they moved in and a plan of care was developed from this. Care plans were not focused on the person nor were they always reflective of people's current needs. Care plans did not properly instruct staff about the action to take to meet individual needs. For example, where people had a high risk of developing pressure sores, the action staff must take to meet this need was not always detailed in the care plan. Information about people's life history and things that were important to the person were recorded for most but not all people. This information was not used as part of the care plan so that care and support could be delivered in a way the person preferred. We spoke with the acting manager who told us they were in the process of making care plans more personalised. They had updated and personalised care plans for 10 of the 26 people who lived at the service.

These matters were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were limited opportunities for people to pursue their hobbies and interests. One person said, "We get entertainers coming in now and then and I watch TV and read. I sometimes get bored." A relative said "They need more activity, my relative watches the TV but I am not sure how much they get out of this." Another relative told us their relative used to do pottery and read a lot but they did not do this anymore. Staff told us they tried to put on activities such as singing but did not always have time to do this. They told us that one person occasionally did some painting and another enjoyed looking at their photograph album.

One person told us they had made a complaint and the provider had taken swift action to resolve the issue and the person received an apology. Another person said, "I have complained once, I think it was dealt with by the manager. I'm satisfied as it hasn't happened since." Another person said they were not aware of the complaints procedure but would feel comfortable complaining to staff.

Records of complaints received showed that the last compliant received was in June 2014. Not all complaints had been recorded because people and their relatives told us about complaints they had made since this time. This meant there was a risk that complaints would not be investigated or responded to appropriately and this was also a missed opportunity for learning and improvement

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who was still working at the service but they were working as a member of the care team. They had resigned from their management position and no longer had any management responsibilities. This was the position at our last inspection in September 2014 and we were informed that they had again taken up the management position in December 2014 and January 2015. The provider had not formally informed us about these management changes as they are required to. Since our last inspection acting managers had taken over the management of the service and at the time of our visit, there was a registered manager from another service temporarily managing this service. Three relatives we spoke with were unsure about who was managing the service.

At our last inspection we identified some concerns with assessing and monitoring the quality of service provision because the provider did not have an effective system in place. This was a breach of Regulation 10 of the Health and Social Care Act 2008, which following the legislative changes of 1st April 2015 corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found that there was very limited evidence to show that the quality of the service was assessed or monitored.

The provider's action plan to address the breaches to regulation found at our inspection in September 2014 stated that actions would be completed by January 2015. The action plan stated that care plans would be reviewed and updated, people and or their relatives would be involved in this review process. Staff would be provided with the training they required and an audit system to monitor the quality of the service would be introduced. At this inspection we found that this action had not been taken and any action the provider had taken had not been effective. We also found that other concerns described in the September 2014 report had not been addressed. These included staff using language in daily records that was disrespectful to people who used the service and people not being offered opportunity to bathe or shower for more than a week at a time.

These matters constituted was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which following the legislative changes of 1st April 2015 corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We were informed that a staff meeting was held when the new acting manager joined the service three weeks earlier. They told us that senior carer meetings and night staff meetings were also held. There had not been a meeting for people who used the service or their relatives for at least four months.

Satisfaction questionnaires were given to people who used the service. This was last done in December 2014. There were 11 questionnaires returned. The majority of comments were positive but a lack of activities and not enough staff had been identified by one person's relative.

Staff told us that the acting manager was supportive and approachable. They felt they could raise any issue and that they would be listened to.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.** **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Regulation 10 (1) (a); from 1 April 2015 this is replaced by Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 (2) (a).**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of assessment, and planning and delivery of care in such a way that meets individual needs and ensures welfare and safety. Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010. From 1 April 2015 this is replaced by Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:
We have issued a Warning Notice which we have asked the provider to comply with by 17 April 2015.