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Broxbourne House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 12 October 2015 and was unannounced.

We previously inspected the service on 9 April 2014 and at that time we found the registered provider was meeting the regulations we reviewed.

Broxbourne House provides accommodation and personal care and support for up to 21 older people some of who might also have a physical disability and or mental health issues such as people who were living with dementia. At the time of our inspection 21 people were living at Broxbourne House.

The service had a registered manager in place. 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.

People we spoke with told us they felt safe at Broxbourne House.

There were not always enough staff available to respond to people in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008

Summary of findings

(Regulated Activities) Regulations 2014, because sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of people who use the service

The registered provider had effective recruitment and selection procedures in place.

Staff had a good understanding about safeguarding adults from abuse and who to contact if they suspected any abuse.

Following incidents or accidents it was not always clear from records what action had been taken to reduce future risks to individuals who used the service.

Whilst most medicines were administered in a safe way for people, some topical creams were not administered as prescribed

People's capacity was not always considered when decisions needed to be made, for example, when deciding to use a door sensor on people's bedroom or to share a bedroom with another person. This evidenced a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because consent was not always sought from the relevant person in line with legislation

Staff had received an induction, supervision, appraisal and training to enable them to provide support to the people who lived at Broxbourne House. This ensured they had the knowledge and skills to support the people who lived there.

People enjoyed the food and had plenty to eat and drink. A range of healthcare professionals were involved in people's care.

Throughout our inspection we observed staff interacting with people in a caring, friendly, manner. Staff were able to clearly describe the steps they would take to ensure the privacy and dignity of the people they cared for and supported.

People did not always receive care that was planned to meet their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans detailed the care and support they required and included some information about people's likes and dislikes. People and their representatives were involved in care planning and reviews. Activities were provided at Broxbourne House, but this was not at a level which would meet the needs of all the people who used the service.

People told us they knew how to complain and told us staff were always approachable. Comments and complaints people made were responded to appropriately.

People we spoke with spoke positively about the registered manager and the registered provider

The registered manager and registered provider were visible in the service and knew the needs of the people who used the service.

There was an open door to the registered manager's office and people, staff and visitors had free access to discuss any relevant matters. This helped to create a culture of openness and transparency

The registered manager held meetings with staff, and surveyed the people who used the service, relatives and staff to gain feedback about the service provided to people.

The registered provider had an overview of the service. They audited and monitored the service to ensure the needs of the people were met and that the service provided was to a high standard, however this system had not picked up the problems we found with staffing, administration of topical medicines, consent to care and treatment and person centred care.

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 always safe

There were not always enough staff available to respond to people in a timely manner

Topical medicines were not always administered as prescribed

Staff had a good understanding about safeguarding adults from abuse

Requires improvement

Is the service effective?
The service was not always effective

People's consent was not always sought in line with legislation

Staff were provided with training and support to ensure they were able to meet people's needs effectively

People told us they enjoyed the food.

People had access to external health professionals as the need arose

Requires improvement

Is the service caring?
The service was caring

People who used the service told us the staff who supported them were caring.

People were supported in a way that protected their privacy and dignity.

Good

Is the service responsive?
The service was not always responsive

People did not always receive care that was planned to meet their individual needs and preferences

Activities were provided but this was not at a level which would meet the needs of all the people who used the service.

People and their representatives were involved in the development and the review of their support plans where possible

People told us they knew how to complain and told us staff were always approachable.

Requires improvement

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

The registered manager was visible in the service and knew the needs of the people who used the service.

Requires improvement

Summary of findings

People spoke positively about the registered manager and the registered provider

The service's quality assurance systems had not identified the problems we identified at the inspection.

Broxbourne 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 inspection took place on 12 October 2015 and was unannounced. The inspection team consisted of two adult social care inspectors.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioners. Before this visit we had received information of concern about the time staff were getting people out of bed in the morning, medication being administered without the consent of the relevant person, mal odour and poor quality food.

We had sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

At the time of this inspection there were twenty one people living at Broxbourne House. Some of the people who use the service were unable to communicate verbally, and as we were not familiar with everyone's way of communicating, we were unable to gain their views.

We spoke with five people who used the service, four members of staff, two relatives, the registered manager, the registered provider and two community professionals. We looked in the bedrooms of six people who used the service. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as staff recruitment and training records, policies and procedures, and quality audits. We looked at five people's care records.

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Is the service safe?

Our findings

One person who used the service said, "I feel safe enough. We have fire drills. They would help us if we were ill. There is a pull cord in the bedroom." Another said, "I feel safe. If I had any complaints I would talk to the boss. I like it here."

During our inspection we observed a homely atmosphere where staff obviously knew people well, however there were not always enough staff available to respond to people who required assistance in a timely manner. We asked the registered manager how staffing levels were decided for the home. They told us they 'observed' the staffing levels. The registered provider said the dependency level of people who used the service was high at the moment.

On the day of our inspection there were three carers on the duty rota on the morning shift (7.15am to 2.45pm) and three carers on the duty rota for the afternoon shift. An activity coordinator worked 20 hours a week from 9.30am until 2pm Monday to Friday. The registered provider told us the activity hours were not replaced during holidays or other periods of absence. At night there was one senior carer and one carer to support 21 people who used the service. The registered manager worked 40 hours a week and the registered provider was on site most days. The registered manager said if it was busy the registered provider helped with personal care. One house keeper worked Monday to Friday 7.15am until 2.45pm and there was no cleaner at the weekends. No laundry staff were employed. The chef was on duty from 7.30am until 3pm Monday to Friday. The chef told us the registered provider and one of the care staff prepared the food at the weekends and when the chef was on annual leave.

We saw between 6.45am and 7.15am there were no staff members present in the lounge with seven people who used the service, many of whom had complex needs. One person who used the service told us they were uncomfortable as their trousers were loose and kept falling down. Another person who used the service helped them to hold their trousers up. The two night staff on duty were supporting people to rise for the day in their bedrooms.

At 11.15am we saw a person walking up and down the corridor asking for the toilet. We were unable to find any care staff. The activity coordinator was in the lounge and the registered manager was in the dining room. We informed the registered manager about this. We were told by a carer that all three care staff take their break at the same time for half an hour. We asked the registered manager how personal care could be completed during this period and they told us the activity coordinator could help them to complete it. The activity co-ordinator told us they would show people to the toilet, but they did not support people with personal care. The registered provider agreed to consider the impact on people who used the service of no carers being available for two half hour periods a day and discuss this with staff.

One relative told us, "At tea time six people need one to one attention. Sometimes it verges on chaos. One carer is doing the laundry. These three girls are so rushed at tea times. Some relatives help people to get the tea. Some of the people who live here need watching." At tea time we saw one member of staff administering medicines and two staff members serving and supporting people with tea. There were 17 people seated in the dining room and three people who used the service seated in chairs in the adjoining room with tray tables. The registered manager told us there were 3 people who used the service who required the assistance of two carers to transfer. If two staff were assisting one person only one staff member would be available to support everyone else. One member of staff told us, "It's okay in the morning but hectic in the afternoon because the activity coordinator and the cook have gone. No agency staff are used, we all work as a team."

The above issues evidenced a breach of regulation 18 of the Health and Social Care Act (2014)

The manager told us some people who used the service who are living with dementia were "livelier" near tea time and they had requested an extra member of staff on the rota between 11am and 6pm. Staffing levels had also been discussed at staff meetings and the registered provider was considering the most effective way to improve staffing levels, by either employing a laundry assistant or adding another carer to the rota to complete laundry tasks and support people who used the service with their tea time meal. The registered manager told us staff preferred the second option and the registered provider agreed to trial this approach with a new rota to include an additional member of staff starting next week. We were provided with copies of this rota after the inspection.

We saw from staff files that recruitment was robust and all vetting had been carried out prior to staff working with

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Is the service safe?

people. This showed staff had been properly checked to make sure they were suitable and safe to work with people. One member of staff had not had their CRB check updated since 2008 and the registered provider agreed to review the frequency with which checks were renewed.

The manager had a good understanding of safeguarding and the procedures to follow to keep people safe. Staff told us they had received training in safeguarding and they were able to tell us what they would do if they had any concerns. Staff gave us a description of the different types of abuse they may come across in their work. One member of staff told us, "I have whistle blown previously at a different home. I would definitely report any suspected abuse." Another said, "Any issues I speak to the manager. I have not witnessed anything inappropriate at this home." This showed that staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

We saw safeguarding incidents had been responded to appropriately and action taken to keep people who used the service safe. We saw the home had a safeguarding policy which had been reviewed and signed as read by staff in August 2014 and was visible around the home. This demonstrated the home had robust procedures in place for identifying and following up allegations of abuse, and staff demonstrated knowledge of the procedures to follow. We noticed one safeguarding incident that had been recorded in the care records of the person and reported to the local safeguarding authorities, who had taken appropriate action. The manager had not, however notified CQC about this incident, in line with legislation. The manager said they would notify CQC in the future of all safeguarding incidents.

We looked at the care records of people who used the service and saw risk assessments were in place for a range of issues including hydration and nutrition, skin integrity, use of bedrails, mobility and falls. We saw these assessments were reviewed regularly, signed and up to date. Risk assessments were tick box in nature with minimal detailed information about how future risks could be prevented to individual people who used the service. However we saw appropriate action had been taken to reduce risks, for example where a person was assessed to be at risk of pressure sores a pressure cushion and air flow mattress were in place. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence.

A series of risk assessments were in place relating to premises and equipment, for example: kitchen safety, water temperatures, use of bedrails, waste disposal, slips, trips and falls, moving and handling equipment, waste disposal and hazardous substances.

We saw servicing and maintenance of equipment such as hoists had been completed regularly and was up to date. We saw documents were maintained in relation to premises and equipment.

We saw in one person's bedroom the headboard was falling off the bed. The registered manager told us they would rectify this. The provider kept a decoration record, which showed the hallway carpet had been changed in November 2014. Prior to this inspection we received information of concern about a rat infestation at the home and a malodour that may have been related to this. The registered provider showed us evidence that the rat infestation had been dealt with by a pest control agency. Following the inspection the registered manager informed us a plumber had found and rectified a leak in an upstairs bathroom that may have been causing the malodour. This showed the registered provider had taken steps to provide care in an environment that was adequately maintained

People who used the service and staff told us they knew what to do in the event of a fire. One person who used the service said, "We have fire drills. When they have a fire alarm we don't have to go out." This showed us the home had plans in place in the event of an emergency situation. We saw from records that fire alarm tests and fire door checks had been completed weekly and checks on fire safety equipment were up to date. Fire drills had been completed approximately annually, although the expected frequency in the homes policy was every six months.

Staff told us they recorded and reported all accidents and people's individual care records were updated as necessary. One member of staff said, "They have a report book for incidents." The manager and staff members were able to describe the procedure to follow and what action had been taken following falls and incidents. We saw accidents and incidents were recorded and appropriate action was taken to ensure the safety of people who used

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Is the service safe?

the service, for example, we saw in one incident report a person who used the service had 'slid down between the gap in the bed rail'. The bed rail was removed and following an assessment by the District Nurse it was replaced with a mesh cot side. In some records it was not always clear what action had been taken to prevent future incidents causing harm to people who used the service. For example we saw a paramedic had been called and a body map completed following a fall for one person who used the service in October 2015. This was an unobserved fall in the corridor at 2.30pm where a person who used the service who used a walking aid was found on the floor. The person did not sustain serious injury. We asked the provider what action was being taken to reduce the risk of future falls, as this was not clear in the records. The registered provider told us, "We keep an eye. All the time (person) is going back and forth."

We noticed one person who used the service had a bruised eye and face. An incident form had not been completed for this incident, which had occurred on the night of 8 October 2015, three days prior to our inspection, although appropriate action was recorded following the incident. We saw in the daily observations on 8 October 2015, 'Cold compress applied. Rang GP next day. Advised by nurse to observe.' The registered manager told us the person had been confused and had difficulty opening their bedroom door. We saw the GP was visiting the person on the day of our inspection with regard to the possible causes of confusion. Apart from contacting the GP it was not clear from the records what action had been taken to prevent a recurrence of the incident. When asked, the registered provider told us observations were increased through the night and a sensor mat was being considered, but this was not recorded.

We saw the registered provider had analysed accidents and incidents across the service to look for themes and lessons learned in May 2015. Incident analyses showed most falls were in bedrooms and two hourly checks at night had been introduced across the home. Two falls were recorded in the garden and action had been taken to improve paving in this area. However we noticed the car parking area directly outside the entrance to the home was uneven. The Registered provider agreed to address this.

Appropriate arrangements were not always in place for the management of medicines. Where people were prescribed topical creams the MAR informed staff to refer to the 'topical application record'. We looked at the topical application record for two people. These were retained in peoples bedrooms and detailed the name of the cream, where to apply it and when. Staff recorded on the form when they had applied the cream. This meant the records accurately reflected when creams were applied to people and by whom. We found in one record cream was prescribed to be applied twice daily, however the record was not signed on 2, 3, 5, 7, 8 and 10 October 2015 in the morning and 2,10 and 11 October 2015 in the evening. On the second topical application record we looked at the record was signed as applied every day that week in the evening, however the MAR sheet showed the prescribed dose was three times a day. This meant people did not always receive their topical medicines as prescribed.

The manager told us senior carers at the home completed training in safe administration of medicines every year and we saw certificates to confirm this. We saw medicines competence was also assessed annually. This meant people received their medicines from people who had the appropriate knowledge and skills.

We saw people's medicines were stored safely. There was a medicines room located on the second floor. The room was spacious and clean with hand washing facilities available. Temperature checks were recorded daily for the rooms where medicines were stored and for the medicines fridge.

We saw a monitored dosage system (MDS) was used for the majority of medicines with others supplied in boxes or bottles. We checked medicines for people and saw that medicines were checked and signed as received by members of staff. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. We noticed that the box of an opened bottle of eye drops was annotated with the date of opening which prevented the person receiving medicine which was out of date.

Care plans also contained information about medicines and how the person liked to take them. A PRN protocol was in place for the administration of PRN medicines. Having a PRN protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

We checked one medicine which was stored in the controlled drugs cupboard. The stock tallied and each

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Is the service safe?

entry was completed and checked by two staff. We noted the staff completed a stock check of all the medicines stored in the controlled drug cupboard to ensure that all the stock was accounted for.

We saw hand wash and personal protective equipment (PPE) was in use around the home and signs showed good hand washing techniques. We saw from staff meeting minutes, staff were reminded to use hand gel and colour coded mops to prevent the spread of infection. All hoist slings were cleaned and checked on a regular basis until 18 September 2015. There was no record of hoist sling cleaning and checks for the following two weeks. The registered manager told us the responsible carer may have taken the paperwork home and they would address this. In one bedroom we went in there was a malodour. The manager told us staff disinfect the room every day and clean the carpet and bed linen and we saw the bedroom had been cleaned and aired. The registered manager told us they would look into the possible causes of the mal odour. A mattress audit had been completed on a monthly basis following advice from local authority infection prevention and control team the previous year. This showed the service was taking steps to ensure the people who used the service were protected from the risk of infection.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. The registered provider had policies in place in relation to the Mental Capacity Act 2005 (MCA). 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.

The registered manager and care staff had completed training and had some understanding of the Mental Capacity Act 2005. One member of staff we spoke with said, "A lot of people here don't have capacity to go out." We saw an MCA assessment had been completed regarding consent to personal care in the care records of two people who used the service. One contained evidence of a best interest discussion and one did not.

The registered manager told us all the bedrooms in the home had door sensors installed. They said a mental capacity assessment and best Interest discussion had not been recorded regarding this decision for all the people who used the service who lacked capacity, because people who used the service and their representatives were aware of the door sensors when they moved in to the home. This demonstrated people's capacity was not always considered when decisions needed to be made so their rights were not always protected.

There were two twin bedrooms at Broxbourne House. Two of the people who used the service had begun to share a bedroom a month prior to the inspection. The shared room was not en-suite and had a privacy curtain for the use of the commode. The registered manager told us both individuals lacked capacity to make bigger decisions. Neither person was able to communicate a decision. We asked the registered manager how the decision had been made that the two people should share a bedroom. The registered manager explained the reasons behind the decision. They told us they had consulted with one person's relative and the other person had a representative who visited on special occasions and signed papers for the Court of Protection as required. There was no evidence of a mental capacity assessment or best interest discussion in the files around this decision for either person. The registered manager agreed to address this. This meant the rights of people who used the service who may lack the capacity to make certain decisions were not always protected in line with the Mental capacity Act (2005) and guidance.

The registered manager told us two people required their medicines administering covertly. Covert administration of medicines occurs when medicine has been deliberately disguised, usually in food or drink, in order that the person does not realise they are taking it. We saw a letter from one person's GP, dated January 2013, giving authority for this person to receive their medicine in this manner. The person had been prescribed new medication since January 2013 and this was not included in the GP letter. The registered manager told us a mental capacity assessment and best interest discussion had not taken place regarding this decision, however the person's son was aware of it. We did not see any record that this discussion had taken place.

There was no evidence of medical authority, mental capacity assessment or best interest discussion regarding the second person. The manager told us it had been discussed with the person's GP and relative, however this could not be evidenced.

The above issues evidenced a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because consent was not always sought from the relevant person in line with legislation

People can only be deprived of their liberty to 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) within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The Registered Manager had a good understanding of the deprivation of Liberty Safeguards (DoLS) and told us three people who used the service had DoLs authorised and two people were awaiting assessment for a standard DoLs authorisation.

The registered manager told us one person who used the service kept trying to leave the home. They told us a DoLs authorisation had been applied for because the person lacked capacity and on one occasion the person went out through the fire exit and over the fence. The person was

Is the service effective?

safely returned to the home. As a result of this incident a 'confused' door handle was installed on the fire exit and this was checked by the fire service in July 2015. We saw the person who used the service had a door sensor installed on the exit door to their bedroom in order to alert staff when they exited the room and this had been agreed as part of their DoLs care plan. The registered manager told us the person's relative was also aware of this.

We saw in the care records of another person who used the service who was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation a condition of the DoLs authorisation was that the person was supported to go for walks outside the home. In the daily reports there was no record of the person being supported to go for a walk outside the home in the last two months. The care plan stated on 28 September 2015, "Staff continue to use distraction techniques such as going for a walk or household chores.". The manager told us the person was becoming increasingly aggressive when required to return to the home and they had stopped attempting to support the person with their walks. This change in the persons care plan had not been updated in the records or reviewed in order to consider the least restrictive alternative and comply with the conditions of the DoLs authorisation. The registered manager said they would contact the relevant person's representative and ensure the person's needs were reassessed and the care plan updated.

Staff were provided with training and support to ensure they were able to meet people's needs effectively. People who used the service told us staff were able to support them well. One relative said, "Some of the new carers are a problem. Lack of training."

We saw from staff files induction training included understanding of the role, safeguarding adults, understanding safety and emergency procedures. We saw evidence in staff files and training records that staff regularly undertook training to enhance their role and to maintain their knowledge and skills relevant to the people they supported. One member of staff told us. "We do all the training. First aid, moving and handling, food hygiene, dementia awareness. I went on a course in Wakefield about the Mental Capacity Act. I would like to do an activities course." We saw from the training matrix staff had recently completed training in topics including end of life care, equality and diversity, Mental Capacity Act, food hygiene, infection control, moving and handling, dementia awareness and catheter training.

One member of staff told us, "I enjoy working here. It's nice and small and friendly and homely." Staff told us they felt supported and staff meetings were held approximately every three months. They told us they had regular supervision every three months and could ask for more if required, as well as an annual appraisal. Supervision records showed supervision was sometimes held less frequently, for example every five or six months. This showed staff were receiving management supervision to monitor their performance and development needs, but this was not always regular. The registered manager said they felt supported by the registered provider and they were supported to update their training regularly.

People at Broxbourne House were supported to have sufficient to eat and drink and to maintain a balanced diet. People we spoke with told us they enjoyed the food. One person who used the service said, "It's very good. The meals are excellent." Another said, "It's really nice." And another said, "Jelly and custard, nice" Another said after lunch, "Well I'm nice and full now. I really enjoyed that." One relative said, "The chef is very clean, fantastic."

We saw people were offered a choice of breakfast and carers and the chef spent time helping people to express their preference. Staff ensured people were supported to eat if required. One member of staff asked a person about moving their tray table closer so they could reach their meal. Carers encouraged people to eat and were attentive to their needs, offering more when people had finished eating. The chef noticed a person who used the service rubbing their hands and offered them a cloth.

There were condiments available on each table. Two people had a plate guard to enable them to eat independently. One person refused a fork and ate their meal with a knife. Staff chatted to people whilst supporting them to eat. The chef was active in supporting people to eat at breakfast and lunch time. They provided a spoon for a person who was struggling to eat with a knife and fork and supported people to eat their desserts towards the end of lunch.

People who used the service told us there was a choice of food and drink and we saw this was the case. One person

Requires improvement

Is the service effective?

who used the service told us, "We get taken down to the dining room for breakfast, lunch and dinner. They have a choice of food. It's pretty good. The cook asks us every morning what we would like to eat." The choice of lunch was displayed on a menu board for the coming week in the dining room, but not the choice for the tea time meal. The chef worked 7.15am until 3pm daily and care staff served a choice of soup and sandwiches for people at tea time.

The chef had a list in the kitchen of people who required special diets or were at risk of poor nutrition and weight loss and would, for example, fortify the mashed potatoes with butter and provide milkshakes for people at risk. We saw in one person's care plan weight had been monitored and action had been taken when weight loss was recorded. A food diary was being kept, including the quantity of food being consumed, the person was referred to a dietician and supplements were being given as prescribed.

People who lived at Broxbourne House were supported to access healthcare. One person who used the service told us, "If we really needed help we would get it straight away." A relative said, "They are good at getting the doctor and dealing with falls." Staff told us systems were in place to make sure people's healthcare needs were met. One member of staff said, "Yes. They get the Dr straight away or the district nurse." They said people attended healthcare appointments and we saw from people's care records that a range of health professionals were involved. People had accessed services in cases of emergency or when their needs had changed. This had included GP's, hospital consultants, community mental health nurses, speech and language therapists and dentists.

Two people who used the service were seeing health professionals at the home on the day of our inspection. A visiting health professional told us, "The staff we spoke to seemed knowledgeable about the person." The home had referred the person via the GP due to concerns about behaviour that challenged and records had been kept about behavioural incidents and possible triggers to those particular events. This showed people who used the service received additional support when required for meeting their care and treatment needs.

We saw there were flowers displayed around the home and photographs on the walls to create a homely atmosphere for people. People who used the service had personalised their rooms. We saw the date and time was displayed correctly in the communal areas. Each of the bedrooms had hand washing facilities. There were two shared bathrooms and a separate toilet downstairs and two shared bathrooms and two separate toilets upstairs. We saw suitable equipment was in place to meet the assessed needs of people who used the service for example: profiling beds, pressure relieving cushions, sensor mats and hoists.

Good

Is the service caring?

Our findings

The service was caring. People told us they liked the staff and we saw there were good relationships between staff and the people who lived in the home. One person who used the service said, "I like it here. Staff are lovely." Another said, "Some of the staff are nice." Another told us, "It's good here. Not bad. The staff are pretty good." One relative said the registered provider, "…is fortunate having the carers he has got. I am here every day. They are very kind. They treat everyone with great respect. They are very sensitive." Another said, "They all seem really nice. They give me a nice impression. (Relative) seems happy with all the staff. They do seem very caring."

Staff we spoke with enjoyed working at the home and supporting people who used the service. One member of staff said, "I love working here. I love getting to know people." Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities and they used this knowledge to engage people in meaningful ways. We saw care files contained information about some of the tastes and preferences of people who used the service, including a short personal history of the person. This gave staff a rounded picture of the person and their life and personal history before they went to stay in the home. One member of staff said, "When new people come in we read the file."

People were supported to make choices and decisions about their daily lives. Staff told us they spoke to family members or the person about their likes or dislikes. We heard staff speak with people in a kind and caring way whilst supporting them to eat and also when offering a choice of meal and drink.

Staff clearly knew people and visitors well. Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. We saw one member of staff used appropriate voice and touch to respond to people who appeared to be uncomfortable.

We saw staff gave good explanations to people to help them understand how they were being supported. We saw they waited patiently for people to respond and people were not rushed in their interactions. We saw one person who was being supported to transfer using a hoist and staff provided reassurance and explained what was happening throughout the process.

The members of staff we spoke with were aware of how to promote the dignity and privacy of people who used the service. We saw staff knocked on people's bedroom doors and asked permission to enter. One member of staff said, "It's about respecting people. How would you want to be treated?" People who used the service looked well presented. One person told us they had their hair washed last night. One member of staff said, "People are well looked after. We put a blanket over one person who uses the service because they pull their clothing up." "I would be happy to place a relative here."

The registered provider had a good understanding of the needs and life history of people who used the service and used this to engage with people in a meaningful way, for example he told us one person who used the service had been a ballet dancer and moved his hands like a ballet dancer, which generated a positive response from the person.

Requires improvement

Is the service responsive?

Our findings

People at Broxbourne House did not always received personalised care that was responsive to their needs. Before this inspection we received information of concern about the time staff were getting people up in a morning. When we arrived at 6am there were a total of five people out of twenty one people who used the service who were in the lounge. One additional person who was able to communicate verbally was outside smoking and told us they chose to get up early. We asked the senior carer on duty why the other five people were up. They told us the people who were up were "wanderers", who had been up in the night and so staff had supported them to dress. The term, "wanderers" did not promote the dignity of people who used the service and the manager later told us they would address this. We asked about the person in a wheelchair and the staff member said the person had required personal care and so they had supported them to rise for the day.

Of the six people who were up, two were able to communicate verbally, however due to cognitive difficulties one person was unable to express their preferences. We asked the person if they liked to get up early and they said, "I don't know." Later in the morning we asked people if they could choose what time they got up. One person said, "No you can't. They get you up early." Another said, "There are no problems at all with the staff. I've got up early all my life." We saw in another person's room topical cream had been applied that morning at 5.30am. The manager told us this person gets up early and strips their clothes off, so they are supported to prepare for the day. This meant another person who used the service was up and dressed shortly after 5.30am bringing the total to seven, one of whom had told us they chose to rise early.

The senior carer on night duty told us people who used the service were able to get up when they wished. The registered manager, registered provider and three care staff we spoke with later in the day said the same. One staff member said, "If people have been incontinent at night they are disturbed in order to assist them. Sometimes they then want a cup of tea and to get up, but they don't have to." We asked the registered manager and the provider how they knew what time people who used the service who were unable to communicate a preference, or lacked the capacity to do so, preferred to get up in the morning. The manager said relatives were consulted, however they were unable to show us evidence of this and the care plans we sampled did not contain this information. This meant this aspect of care was not designed with a view to achieving service users' preferences. This evidenced a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Care plans were in the style of tick boxes but did contain some personalised information regarding people's tastes preferences and life history. For example, "X likes to look smart at all times. X likes to have nail varnish on." Some specific information was recorded to enable staff to deliver person centred care, for example, "Staff must put knife and fork in hand and tell (person) that their food is in front of them so they knows to eat it." The staff we spoke with had a good awareness of the support needs and preferences of the people who used the service. Care plans contained information on nutrition, night time, medication, mobility, personal care, oral care and mental wellbeing. They included goals and the actions taken to achieve the goals, for example, 'encourage (person) to join activities to keep mentally active'. One goal was recorded to improve mood and wellbeing, and the action required was, 'Talk to (person) about things they like eg: life as an only child, their dog'. They also contained pre-admission information. One person's care plan states '(Person) likes a bath/shower at least once a week'. There was no evidence the person had received a bath week commencing 5 October 2015. The registered manager told us they would address this.

We saw information in most of the care plans we sampled had been updated to reflect peoples changing needs, for example a change in the support a person needed to transfer. Care plans were updated every month or as necessary and we saw care plan evaluation dates on a board in the office.

A relative told us, "We have meetings and reviews. The manager keeps me informed." We saw people had been involved in planning their care. Where this was not possible or not desired by the person, their family and other relevant health and social care professionals had been involved

Activities were provided at Broxbourne House, but this was not at a level which would meet the needs of all the people living at the home. One person who used the service said, "A lady comes in to do my nails." Another told us, "There are no activities. The hairdresser comes on Wednesdays." One person said, "I had plenty of hobbies at home. Woodwork.

Requires improvement

Is the service responsive?

We do very well." One person told us the registered provider took them in to town occasionally. Another person said, "I don't do activities. I don't like TV. I like pottering around."

The registered manager told us an activity co-ordinator worked at the home for 20 hours a week, Monday to Friday 9.30 till 2pm. The activity coordinator said, "We have a quiz or bingo in the afternoons. Some play dominoes. We used to go to town on the bus. We don't go any more if people don't have a bus pass." The manager told us a singer came in to perform every three weeks or so. When we looked at the activity records no full five day weeks of activities were recorded in the activities book between January 2015 and August 2015. The registered manager told us this may be due to staff absence or lack of recording and they would address this.

People who were able to do so and relatives, told us they would feel comfortable raising issues and concerns with any of the staff and they knew how to complain. One person who used the service said, "I would talk to the manager if I was concerned." One relative said, "I have shared my concerns with (name of provider). Yes they have acted on concerns. I was concerned about security and he did something about that. There is no formal feedback though. I suggested some."

One member of staff said, "No one has ever complained to me. I would go to the managers if they did."

The service had a complaints procedure which was visible in the home. The registered manager told us, "We have an open door policy. We record complaints and the action taken." We saw the complaints record showed where people had raised concerns; these were documented and responded to appropriately. For example; two complaints were recorded where a person was wearing another person's clothes in February and March 2015. We saw the issue with laundry was discussed at the staff meeting and action was taken to address the issue. One person's relative told us their relative had recently had a fall and they were unhappy the home did not inform them of this until two days after the incident occurred. The registered provider told us they would address this with staff. They told us the relative had not yet filled in a form to be contacted out of hours if there were any incidents. The relative completed the out of hours contact form on the day of our inspection. This demonstrated people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care

Requires improvement

Is the service well-led?

Our findings

One person who used the service said the registered provider, "Has been a gentleman with me. He does look after us." Another said, "It's alright here. I've not been here long." The relatives we spoke with told us they had confidence in the registered provider and the registered manager to support their relative and address any concerns. One relative said, "I couldn't speak too highly of the manager." One member of staff told us, "This is one of the best homes I've worked in." Another said, "I like the atmosphere here. Everyone works as a team."

The registered manager and the registered provider were visible 'on the floor' and had a good knowledge of the needs of people who used the service. They both worked 'hands on' with people who used the service and offered confident direction and leadership within the home which enabled staff to understand their roles and responsibilities. Most people who used the service enjoyed interaction with the registered provider who tried to provide a convivial and friendly atmosphere joking with people who used the service, which most people responded to in a positive way, smiling and laughing. We observed the registered provider showing one person who used the service to the toilet. The person said, "I might not want to go when I get there." The registered provider laughed and said to another person who used the service, "Did you hear that?" and repeated what the person had said. The person who used the service asked, "Are you laughing at me?" We discussed this with the registered provider and they accepted the person's dignity was not protected on that occasion and the comments were not a good example to staff of dignity and respect for people who used the service.

There was an open door to the registered manager's office and people, staff and visitors had free access to discuss any relevant matters. This helped to create a culture of openness and transparency

The registered provider told us they kept the team up to date with good practice by bringing practice updates into the home for staff to read on topics such as, living well with dementia. We saw information available for staff to read on the staff notice board.

Representatives of people who used the service and staff were asked for their views about care and treatment but people who used the service were not always consulted.

One person who used the service told us, "There are no meetings for people who use the service." The homes quality assurance policy stated, "Service users meetings are held every three months," however the last meeting recorded was held in December 2012. The manager told us this was because only a few relatives visit and most people who use the service are unable to participate in meetings. We discussed other ways of engaging people who use the service in order to gain their views.

Quality surveys had been completed with people who use the service and their relatives in order to gain their views and we saw the results were analysed in April 2015. Feedback from people who used the service and relatives who responded to the survey was largely positive with 100% saying they were happy with their care and 72% agreeing they were involved in their care. 81% agreed the meals were hot enough and there was plenty and 100% of respondents knew how to complain.

We saw staff meetings were held regularly and topics covered included cleanliness, activities, keyworker role, care plans, redecoration of the home and quality assurance. One relative told us, "I went to a staff meeting and made some suggestions." Meetings with staff, people who lived at the home and their relatives are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment.

We saw from the staff survey results and staff meeting feedback the registered provider had taken action to address concerns, for example, by improving the outside space for people who used the service, redecorating the entrance hall and replacing some carpeting and purchasing electronic weighing scales. This meant the registered provider was keen to learn from others to ensure the best possible outcomes for people living within the home.

We saw audits were maintained in relation to premises and equipment. There was evidence of internal daily, weekly and monthly quality audits and actions identified, for example the weekly medication audit had picked up some signatures missing in handwritten entries on MAR sheets and this had been followed up. The audit had not, however picked up the problems with administration of topical medicines. Audits included; medication, skin integrity, infection control, care plan evaluations and training.

Requires improvement

Is the service well-led?

This demonstrated the management of the organisation were reviewing information to improve quality in the organisation. However, the service's quality assurance systems had not identified the problems we identified during the inspection.

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care The care and treatment of people who used the service was not always designed to meet their needs and preferences. Regulation 9 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for Consent Care and treatment of people who used the service was not always provided with the consent of the relevant person Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

This section is primarily information for the provider

Action we have told the provider to take

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of people who use the service

Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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