

Flightcare Limited

Broadway Nursing

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?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 24 and 25 January 2017 and was unannounced.

Broadway Nursing is a nursing and residential care home that provides accommodation, nursing care and support for up to 43 adults some of whom have complex needs. The service is situated in the Clubmoor area of Liverpool and was close to shops, pubs and other places of local interest. At the time of the inspection there were 38 people living in the home.

When we last inspected Broadway Nursing in July 2014, the provider was found to be compliant with regulations and the service was rated good in all domains and overall.

A registered manager was 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.

During this inspection we found that risk in the environment was not always minimised. For instance items that could pose risks to vulnerable people, such as razors, were not always stored securely. The door to one person's room did not close as the automatic closure device was broken. We discussed this with the registered manager and this was repaired by the second day of the inspection. Some radiators around the home were very hot to the touch and could pose a burns risk. Both internal and external checks were completed regularly to help ensure the building and equipment was safe, however water temperatures were not all in safe ranges and were awaiting repair.

Medicines were not always managed safely in the home. Temperatures of the storage room and medicine fridge were meant to be recorded daily, but these checks had not been recorded daily. There were no plans in place to ensure people received medicines prescribed as needed (PRN) when they needed them. Prescribed thickening agents were not signed as administered and recording of allergies was not consistent.

We received mixed feedback regarding staffing levels from relatives and people living in the home, though staff told us there were sufficient numbers of staff to meet people's needs. Our observations showed us that there were sufficient numbers of staff on duty, but they were not always deployed most effectively.

Staff told us that they received regular training, though not all staff had completed safeguarding training and two staff had not undertaken medicine training or had their competency assessed.

Staff told us that they felt well supported and that they could approach the registered manager if they had any concerns. There did not appear to be programme for staff supervision as they had only been held in January 2016 and appraisals in October 2015. Staff that were new to care had completed an induction which

was in line with the principles of the Care Certificate.

Staff we spoke with told us they always asked for people's consent before providing care. When people were unable to provide consent, mental capacity assessments were completed. Though most of these were completed appropriately, some of the assessments did not follow the principles of the Mental Capacity Act 2005.

Our observations showed that the quality of interactions between staff and people living in the home varied. We observed some very warm and positive interactions during the inspection. However, we also observed interactions that were not as positive.

Care files were not always stored securely in order to maintain people's confidentiality. This meant that people could access confidential information that did not need to.

We found that although audits were completed to assess the quality of the service, actions were not always taken to address issues they identified. Issues identified through an external service risk assessment had not all been addressed by the provider. The provider was aware of issues within the home through regular visits and an internal quality assurance monitoring schedule.

Care plans that had been reviewed using the newly introduced care plan system were detailed and person centred, however those that had not yet been reviewed using the new approach lacked detail and personalised information. Not all care plans reflected accurate information regarding people's needs and preferences. This meant that not all staff had accurate information regarding people's needs.

Planned care was not always evidenced as provided. For example, one person's care file reflected they required their blood pressure to be monitored monthly due to a health condition, but this had not been completed. We also found that risk assessments regarding people's care needs were not always completed accurately to identify the correct level of risk.

People we spoke with told us they felt safe living in Broadway Nursing. Staff had a good understanding of safeguarding processes and staff were recruited following relevant checks to ensure they were suitable to work with vulnerable people.

DoLS applications had been made appropriately for people who required one.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. People told us they were supported to access medical services when required.

Feedback we received regarding meals was positive. Staff were knowledgeable about people's dietary needs and preferences. People had a choice of main meal and alternatives were always available. People could have snacks when they wanted them and they had plenty to drink

People living at the home told us staff were kind and caring and treated them with respect. We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms. People told us staff supported them to maintain or improve their independence when supporting them.

We found on discussion, that staff knew the people they were caring for well, including their needs and preferences. Care plans included information regarding people's preferences.

Care files included detailed information regarding any medical conditions the person had, such as signs and symptoms and a definition of the condition. This helped to ensure that staff had an awareness of people's individual medical needs and how these may impact on the person.

Most people we spoke with did not recall being involved in their care plan but thought that their family members were involved.

People told us their cultural and religious needs were met by the service. One person told us about a priest who visited the home each week and provided individual Holy Communion.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained.

For people who had no family or friends to represent them, contact details for a local advocacy service were available within the home for people to access.

People had access to call bells in their rooms to enable them to call for staff support when required.

There was an activities coordinator employed by the service and people told us they were very enthusiastic and provided a number of activities. There was a planned schedule of activities advertised and we observed bingo and karaoke take place during the inspection.

People living in the home that we spoke with were not aware of any meetings or questionnaires to gather their feedback. Relatives we spoke with confirmed they received annual surveys and we found that these were last issued to people in 2016. There was however, no evidence to show that this feedback had been acted upon. Most people we spoke with were not aware of resident or relative meetings and there were no records to show when these were last held.

People had access to a complaints procedure and this was displayed within the home and available within the service user guide. People we spoke with told us they had not had reason to make a complaint, but knew how to raise an issue should they have to.

Staff told us they enjoyed working at the home and one staff member described Broadway Nursing as a happy home. Staff told us that they worked well together as a team to meet the responsibilities of their roles and the values of the service.

The provider had policies and procedures in place to guide and inform staff on all aspects of their role. Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

Staff we spoke with told us they had regular team meetings and felt able to share their views during these meetings and that they were listened to.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Broadway Nursing.

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

The service was not always safe.

Risk assessments were not always accurate to help ensure appropriate risk reduction measures could be implemented to maintain people's safety and planned care was not always evidenced as provided.

Medicines were not always managed safely in the home.

Arrangements were in place for checking the building and the equipment to ensure it was safe, though some repairs were outstanding.

We received mixed feedback regarding staffing levels. Our observations showed us that there were sufficient numbers of staff on duty, but they were not always deployed most effectively.

People we spoke with told us they felt safe living in Broadway Nursing.

Staff had a good understanding of safeguarding processes and staff were recruited following relevant checks to ensure they were suitable to work with vulnerable people.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff did not receive supervision or an annual appraisal regularly to support them in their role. An induction was available which was in line with the principles of the Care Certificate.

Staff received training in a variety of areas, however not all staff had completed safeguarding training and two staff had not undertaken medicine training or had their competency assessed.

DoLS applications had been made appropriately. When people were unable to provide consent, mental capacity assessments were completed but these did not all follow the principles of the Mental Capacity Act 2005.

Requires Improvement ●

Feedback regarding meals was positive. Staff were knowledgeable about people's dietary needs and preferences.

Is the service caring?

The service was not always caring.

Confidential care records were not always stored securely.

Our observations showed that the quality of interactions between staff and people living in the home varied.

People told us staff were kind and caring and treated them with respect. We observed people's dignity and privacy being respected by staff in a number of ways during the inspection. People told us staff supported them to maintain or improve their independence when providing support.

We found on discussion, that staff knew the people they were caring for well, including their needs and preferences.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Some care plans lacked detail and personalised information. Not all care plans reflected accurate information regarding people's needs and preferences.

Relatives told us they were kept informed of any changes to their loved one's health and wellbeing.

There was a planned schedule of activities advertised and we observed bingo and karaoke take place during the inspection.

People had access to a complaints procedure and this was displayed within the home and available within the service user guide.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Audits were completed to assess the quality of the service; however actions were not always taken to address issues they identified.

The provider and management team were aware of issues within the home through internal quality assurance monitoring.

Requires Improvement ●

Policies and procedures were in place to guide and inform staff on all aspects of their role. Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The registered manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notifications.

Broadway Nursing

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 24 and 25 January 2017 and was unannounced. The inspection team included two social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance, their experience related to care of older people.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, care quality manager, the maintenance person, an activity coordinator, three members of the care staff, six people living in the home and five relatives.

We looked at the care files of six people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Is the service safe?

Our findings

During our last inspection in July 2014, we found that the provider met Regulations in relation to safety and the safe domain was rated as 'Good.'

During this inspection, the registered manager showed us around the home and we found that items that could pose risks to vulnerable people were not always stored securely. For instance, we saw that razors were stored in an accessible container within an unlocked room. Another example was that toiletries were observed to be stored in a room where the door did not close due to boxes being placed next to it. We highlighted these concerns to the registered manager on the first day of the inspection, however we found on the second day of inspection that the items were still not secured securely. Since the inspection the registered manager has told us that a sign has been put on the doors to remind staff to keep them closed and locks have been ordered for these doors to ensure all products that could pose risks to vulnerable people, are securely stored.

We also found that the door to one person's room would not close as the automatic closure device was broken. We discussed this with the registered manager and this was repaired by the second day of the inspection. Some radiators around the home were very hot to the touch and could pose a burns risk. The registered manager has confirmed since the inspection that bespoke covers for the radiators were being sourced.

The area of the home used for people to smoke in was not in line with Smoke free England regulations as it was not signed as a designated smoking area and did not have automatic closure devices on the doors to prevent smoke drifting into other areas of the home. The registered manager has told us since the inspection, that a new smoking shelter will be provided outside the home.

Water temperature checks were undertaken regularly and issues had been identified regarding the temperature at some outlets. We discussed this with the registered manager who told us that the contractors who were working within the home would also be addressing the water temperatures.

We looked at how medicines were managed within the home and found that safe practices were not always adhered to. We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. We found that medicines were stored securely in a locked clinic room.

Best practice guidance was not always adhered to in relation to medicines management. For instance, temperatures of the storage room and medicine fridge were recorded, but not always daily. Eye drops were not dated when opened to ensure they would not be used after 28 days as their efficacy changes after this period of time.

There were no plans in place to guide staff when to administer as required medicines (PRN) to people who

were unable to inform staff when they needed it. PRN medications are those which are only administered when needed, for example, for pain relief. This meant that people may not receive the medicines they require at the time they need it.

We viewed the MAR charts and found that medicines administered were not always clearly recorded. For example, one person who was prescribed a thickening agent in their drinks due to swallowing difficulties, had not had this medicines signed for at all. We were told the person did receive the thickening agent with each drink but there were no records to evidence this. Another person's MAR chart used a code to show a medicine had not been administered; however the reverse of the chart had not been completed to explain why the medicine had not been given.

People's allergies were not consistently recorded within medicine files. For instance, one person had an allergy recorded on their MAR chart but on their front sheet it was recorded that they had no allergies. This meant that there was a greater risk the person may be given a medicine they were allergic to.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, moving and handling, use of bed rails and pressure area relief. We found however, that they were not always completed accurately. One person's risk assessment in relation to their skin integrity indicated a lower level of risk than they should have been scored, as not all of their medical conditions had been taken into account. Another person had a risk assessment in place in relation to smoking. From our observations during the inspection we could see that the risk reduction measures highlighted on the risk assessment were not being adhered to. We discussed this with the registered manager who told us that the person's needs had changed and the risk assessment no longer reflected the necessary care and they would ensure this was updated as a priority. This meant that not all staff may have had access to accurate information regarding risk to people.

We also found that planned care was not always evidenced as provided. For example, one person's care file reflected they required their blood pressure to be monitored monthly due to a health condition. There was no evidence this had been completed and when we discussed this with the registered manager they confirmed no clinical observations had been completed for any people living in the home for a number of months. They had realised this and developed charts to be put into care files to help ensure observations were monitored regularly. We requested that staff checked the person's blood pressure during the inspection as per their plan of care and this was completed. This meant that people may not have received safe care and treatment based on their identified needs.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

MAR charts that were handwritten were signed by two people in line with good practice and there were systems in place to ensure medicated patches were applied in different areas of a person's body as required.

A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, refusal of medicines, controlled drugs and covert administration of medicines (medicines hidden in food or drink). Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

We looked at how the home was staffed. On the first day of inspection there were two nurses, eight care staff, two domestics, an activity coordinator, a chef, kitchen assistant and maintenance person on duty, as well as the registered manager and care quality manager, to provide care and support to 38 people living in

the home.

When we asked people their views as to whether there were enough staff on duty to meet people's needs, the feedback was mixed. One person told us, "Oh yes, there's always someone, including at night." Another person however, told us, "No not really." Most relatives we spoke with told us there were always staff around, though people often waited for call bells to be answered. For example, one relative told us, "[Relative] can wait 20-30 minutes for the toilet, especially at meal times" and another relative said, "When [relative] presses their buzzer they are waiting too long." Staff we spoke with told us there were enough staff on duty to meet people's needs in a timely way. One staff member told us, "Staffing levels are good; people don't have to wait long. We have a target of three minutes" and another staff member told us there were enough staff as there had been an increase in staffing levels recently.

During the inspection we observed people receiving care in a timely way and call bells were answered after short periods. We did however, observe staff talking to each other in groups or finishing drinks before answering call bells. We could hear a bell ringing and looked at the call system to see who it was. At this time we heard staff talking about who it was that was calling and what they wanted, but nobody had gone to answer the bell. We discussed this with the registered manager who told us they would discuss this further with staff and ensure that staff were aware of their responsibilities and to respond promptly to call bells if they were available.

People we spoke with told us they felt safe living in Broadway Nursing. One person told us it was because, "Staff keep an eye on you" and another person said, "I'm better looked after here and safer [than at home]." All relatives we spoke with agreed that their family members were safe in the home. One relative told us, "When I go home I know they're being cared for."

We spoke with staff about adult safeguarding and how to report any concerns. All staff we spoke with were able to explain how they would report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made to the Local Authority for investigation.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record to ensure they are suitable to work with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

External contracts were in place to monitor areas such as gas, electric, lifting equipment and legionella and these were in date. Internal checks were also completed, such as fire alarm testing, fire door checks, nurse call systems, window restrictors, bed rails and radiator checks.

People had a PEEP (personal emergency evacuation plan) completed, to ensure their safe evacuation in the event of a fire.

The home displayed a food hygiene rating of five, which is the best score available. We discussed this with the chef and registered manager as the PIR provided by the service prior to the inspection stated the rating was a two. We were told, and could see, that the kitchen had been fully refurbished since the last rating. Following the inspection we found that the food standards agency had not re inspected since the refurbishment and the rating remained at two. We made the registered manager aware of this who has since

informed us they have requested a further food hygiene inspection as they believe all standards will now be met.

The service also had a business contingency plan in place to ensure the service could continue in the event of an emergency. This had recently been actioned following a power cut to the home. Staff we spoke with felt that this incident was managed well and people continued to receive appropriate care until the power was reinstalled.

We looked at accident and incident reporting within the home and found that these were reported and recorded appropriately to help ensure people's safety.

The home appeared to be mostly clean and well maintained. People we spoke with agreed and one person told us, "Yes it is clean enough" and another person said, "Yes, my room is cleaned every day." We found that there was liquid soap, paper hand towels and hand sanitiser available in bathrooms in line with good practice guidance. We observed staff wearing personal protective equipment such as gloves and aprons at appropriate times during the inspection. The smoking area was not clean and cigarette butts were scattered over the floor.

Is the service effective?

Our findings

During our last inspection in July 2014, we found that the provider met Regulations and the effective domain was rated as, 'Good.'

During this inspection we looked at on going staff training and support. Staff told us that they felt well supported and that they could approach the registered manager if they had any concerns, however there had not been any regular supervision or appraisals completed recently. Records we viewed showed that the last supervisions had been held in January 2016 and appraisals in October 2015. The registered manager told us that they were aware that supervisions had not been held and had developed a matrix for 2017 to record staff supervisions, though these had yet to commence.

Staff we spoke with told us that they received training in a variety of areas, such as the Mental Capacity Act, moving and handling, dementia, fire safety, food hygiene and first aid. Clinical training was also available to nursing staff; and recent courses included wound care and diabetes. People we spoke with told us that staff were well trained and knew how to support them. Comments included, "Yes, I do think they're trained well, they work their way up" and "Yes staff know what they are doing, including people with dementia."

The training matrix showed that not all staff had received safeguarding training. The registered manager told us that a training session was arranged for the week following the inspection as they had already identified that this was required. We also found that two of the nursing staff had not undertaken medicine training despite administering medicines and there was no evidence that they had had their competency checked. We discussed this with the registered manager who arranged training for both staff members the following day and since the inspection has confirmed that competency assessments have also now been completed. Records we viewed showed that all other staff who administered medicines had attended training and had their competency assessed. This meant that staff may not be receive sufficient training and supported to assist them to carry out their role effectively.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff personnel files to establish how staff were inducted into their job role. We found that staff that were new to care had completed an induction which was in line with the principles of the Care Certificate and records we viewed evidenced this. The Care Certificate is an identified set of standards that health and social care workers work towards and have their practice assessed and signed off by a senior member of staff. Staff we spoke with told us their induction was sufficient to enable them to support people effectively.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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).

The registered manager told us that 23 DoLS applications had been made to the Local Authority but none had been authorised as yet. There was a system in place to inform staff who had an application in process. We found that DoLS applications had been made appropriately and copies of the applications were available within people's care files.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, before entering a person's bedroom and when providing support at lunch time. People we spoke with agreed that staff asked them for their consent before providing care and comments from people included, "Yes, they always do" and, "Yes, they're pretty good like that."

When people were unable to provide consent, mental capacity assessments were completed. The registered manager told us and care records showed, that care plans were being developed and this included the completion of mental capacity assessments. Those care files that had been reviewed contained assessments that followed the principles of the MCA. We saw that most care files we viewed contained completed mental capacity assessments that were in line with the principles of the MCA, but this was not always consistent. For example, one care file showed that a person lacked capacity to understand the consequences of refusing their medicines. Records clearly reflected that the GP, pharmacist and family had been involved and agreed it was in the person's best interest to administer the medicine covertly. Another person's file reflected that they had an independent mental capacity advocate (IMCA) to act for them in decision making as they were unable to do this themselves and did not have family to support them. Another care file however, showed that a person lacked capacity to make decisions regarding their daily living needs, but there was no evidence that relevant people had been consulted and that a decision had been made in their best interest.

We recommend the service reviews its procedures and ensures it is working within the principles of the Mental Capacity Act 2005.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment when required from relevant health and social care professionals, such as the GP, optician and dietician. Referrals to other health professionals were made in a timely way when people's needs changed, such as to the speech and language therapist or falls prevention service. One example of this was a person who had recently developed difficulty in swallowing and their care file showed that a referral had been made to the speech and language therapist and were awaiting an assessment. In the meantime staff were offering the person a softer diet to reduce risks.

People told us they were supported to access medical services when required and that a GP visited them quickly if they were unwell. One person told us about a time they were unwell and staff arranged for an ambulance to take them to hospital very quickly. Relatives told us that they were kept informed of any changes in their family member's health.

We asked people about the food at Broadway Nursing and people described the food as, "Good all the time", "The food is alright" and, "Some I like, some I don't." People told us there were alternatives available to them if they asked. A relative described how it had been difficult for their family member to adapt when

their dietary needs changed and staff arranged for the chef to speak with them and discuss options available and told us, "Now we're more than happy." People told us they could have snacks when they wanted them and that they had plenty to drink. We observed jugs of juice available in the lounge and in people's rooms.

Some people chose to have a fridge in their room to store food items provided by their family and one person told us the chef often prepared them a meal from items their family had brought in.

We observed lunch on the first day of inspection and found that the tables were laid with table cloths and cutlery but there were no placemats, condiments or menus available to people on the tables. The dining room was very quiet. Staff were available to support people to eat and we observed little conversation between staff and people living in the home during this time. We discussed this with the registered manager who told us they would look into meal time experiences.

We spoke with the chef who was knowledgeable about people's dietary needs and preferences. They told us people had a choice of main meal and that each person was asked of a morning what they would like and that alternatives were always available. We observed a record of what people had chosen that day and could see alternatives to the two main choices that were provided. Staff we spoke with were also aware of people's preferences and dietary needs and could tell us who required thickening agent in their drinks, or whether people used adapted cups when drinking.

We observed the environment of the home and found that the registered manager had taken steps within the home towards the environment being appropriate to assist people living with dementia, with orientation and safety. For instance, bathroom doors were red so that people could easily identify them. There was an orientation board in the lounge which informed people of information such as the date and the weather. Some bedroom doors had photographs on to help direct people to their room and the registered manager told us they planned to further develop this with numbers and door knockers on doors. The registered manager told us they hoped this would help people to feel that it was their space.

Is the service caring?

Our findings

During our last inspection in July 2014, we found that the provider met Regulations and the caring domain was rated as, 'Good.'

During this inspection we found that care files were not always stored securely in order to maintain people's confidentiality. For example, on the first day of the inspection we were showed around the home and seen that a number of care files were left on a table in the lounge unattended. This meant that people could access confidential information that did not need to. The registered manager then ensured the files were stored securely and we found this for the duration of the inspection.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home told us staff were kind and caring and treated them with respect. People told us staff were, "All alright", "Pretty good" and that, "There are no nasty staff." Relatives agreed staff were kind and one relative described staff as, "Really good."

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms. Personal care activities were carried out in private and people did not have to wait long if they needed support. People were given plenty of time to eat their meals; they were not rushed in any way. People we spoke with told us their dignity and privacy was maintained; comments included, "If I asked [staff] not to come into my room they wouldn't", "They pull the blinds and knock on my door" and, "Yes, they pull the curtains and always knock on the door and wait."

Our observations showed that the quality of interactions between staff and people living in the home varied. We observed some very warm and positive interactions during the inspection. For example, we observed a staff member sitting with a person in the lounge and chatting to them and other staff talking to a person whilst supporting them to transfer using a hoist, offering reassurance throughout. However we also observed interactions that were not as positive. For example, we observed a staff member cross the lounge and move a person in their wheelchair from behind, without any warning or discussion. We observed a number of staff sitting together in the lounge and shouting across the lounge in response to people's questions, rather than going over to talk to people. A further example was when a person asked to go to their room at 16.05; a staff member told them to wait until 16.30, with no explanation as to why they had to wait. We observed the person go to their room themselves a few minutes later without the requested support from staff.

We asked people if staff supported them to maintain or improve their independence and feedback was positive. One person told us staff cut up their food for them so they could eat independently with a fork and another person told us staff gave them a cup with a lid on when drinking in their room so they could manage on their own. Most relatives we spoke with agreed; one relative told us staff allowed their family member to

attempt to dress themselves before providing assistance.

We found on discussion, that staff knew the people they were caring for well, including their needs and preferences. For instance, staff we spoke with had knowledge of people's preferred drinks and foods. People we spoke with told us that staff did know them well. One person told us staff knew them well enough to cheer them up when they felt down and another person told us staff probably knew them, "Too well." Staff agreed that they had time to get to know people, from talking to them or reading their care plan.

Care plans we viewed included information regarding people's preferences, in areas such as food, drinks, activities, daily routines and whether people had a preference of the gender of care worker who supported them with their personal care needs. Care files also included a 'what's important to me' document and a 'this is me' record. These provided information specific to the individual and included areas such as family, occupations, daily routines, preferred bedding and favourite foods, as well as foods people did not like. Newly reviewed care files included a place for keyworkers to sign to indicate they had read and understood people's care plans.

People told us their cultural and religious needs were met by the service. One person told us about a priest who visited the home each week and provided individual Communion. When we spoke with the chef they told us they always met people's cultural dietary needs and until recently had provided individual meals based on a person's cultural needs.

Care files included plans which reflected people's end of life wishes. The registered manager told us that an end of life coordinator had recently been employed and that staff were working with the community matron to improve their knowledge regarding advanced care planning.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with and their relatives agreed that they could visit at any time and could visit in private if they wished to.

For people who had no family or friends to represent them, contact details for a local advocacy service were available within the home for people to access. Advocacy details were also provided within the service user guide which was available in people's rooms. The registered manager told us that one person had an IMCA involved in their care to act on their behalf as the person did not have any family members to support them and care records reflected this.

Is the service responsive?

Our findings

During our last inspection in July 2014, we found that the provider met Regulations and the responsive domain was rated as, 'Good.'

During this inspection we looked at how people were involved in their care planning. Most people we spoke with did not remember seeing their care plan but thought that their family members were involved in the creation and review of their planned care. One relative we spoke with agreed and told us they had recently been involved in a review of their family member's care and had signed the care plans to indicate their agreement. However, most other relatives told us they did not recall seeing a care plan or being involved in a review since their family member first moved into the home. The registered manager told us that they had recently put up a poster inviting relatives to take part in reviews of their family members care plan and we saw one of the posters on display during the inspection.

We viewed care plans in areas such as personal care, nutrition, medicines, mobility, mental state and skin integrity. We found the quality of the care plans varied with regards to accuracy and person centred approach. Care plans that had been reviewed using the newly introduced care plan system were detailed and person centred, however those that had not yet been reviewed using the new approach lacked detail and personalised information. For example, one care plan that had been reviewed included a plan regarding a person's ability to mobilise. It guided staff on the person's needs, what equipment was required, the size of sling to be used and the need to explain the process as they supported the person. Another person's care file included a mobility plan that informed staff that, "Full manual handling assessment to be carried out and needs to be identified and ensure staff know correct equipment to be used."

We found that although care plans had been reviewed each month, not all care plans reflected accurate information regarding people's needs and preferences. For instance, one person's care plan overview stated that the person preferred two female staff to support them. However their personal care plan stated they required one carer, male or female. We discussed this with the registered manager who confirmed the person required two staff and preferred female carers. This meant that not all staff may have accurate information regarding people's needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Files did include detailed information regarding any medical conditions the person had, such as signs and symptoms and a definition of the condition. This helped to ensure that staff had an awareness of people's individual medical needs and how these may impact on the person. We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily handovers between staff and through viewing people's care files.

Relatives we spoke with told us they were kept informed of any changes to their loved one's health and wellbeing. Care files included a care plan profile which provided staff with a brief overview of people's main needs in relation to their care and support. This helped to ensure that all staff providing care to people were aware of their needs and preferences.

People had access to call bells in their rooms to enable them to call for staff support when required. One person we spoke with told us that staff always ensured they had everything they need to hand as they were unable to reach things if they were not left close by.

We asked people to tell us about the social aspects of the home. There was an activities coordinator employed and people told us they were very enthusiastic and provided a number of activities. There was a planned schedule of activities advertised such as film afternoons, exercises and external entertainers and we observed bingo and karaoke take place during the inspection which people in the lounge appeared to participate in and enjoy. One person told us there was a visiting library and other people we spoke with told us they preferred to stay in their room and watch television or listen to the radio. Parties were held to celebrate people's birthdays and special events throughout the year. Relatives told us they would like to see more activities available and this was reflected in last year's quality assurance surveys.

We looked at processes in place to gather feedback from people and listen to their views. People living in the home that we spoke with were not aware of any meetings or questionnaires, but relatives we spoke with confirmed they received annual surveys to gather their feedback. Records showed that quality assurance surveys were last issued to people in 2016 with a quarter of responses received. Surveys asked people for their views in areas such as staff, daily care, privacy and independence, food and comfort and cleanliness and results showed a high level of satisfaction in these areas. Responses regarding activities showed that most people would like more activities, particularly outings. There was however, no evidence to show that this feedback had been acted upon. Most people we spoke with were not aware of resident or relative meetings and there were no records to show when these were last held. People we spoke with however, felt able to raise any issues as and when they needed to.

People had access to a complaints procedure and this was displayed within the home and available within the service user guide. People we spoke with told us they had not had reason to make a complaint, but knew how to raise an issue should they have to. People were aware there was also a complaints book that could be used. There was a complaints log maintained by the registered manager. We viewed one complaint that had been made and records showed that this had been dealt with appropriately in line with the provider's complaint policy.

Is the service well-led?

Our findings

During our last inspection in July 2014, we found that the provider met Regulations and the well-led domain was rated as, 'Good.'

During this inspection we looked at systems in place to monitor the quality and safety of the service. Some areas of concern had been addressed, such as care plans that had not been reviewed for seven months and topical creams not being signed for. An audit of DoLS applications had also been completed and those people identified as in need of an application now had one completed. However, not all concerns had been addressed. We found however, that although audits were completed to assess the quality of the service, actions were not always taken to address issues they identified. For example, a quarterly health and safety audit reflected that filing cabinets were not secured to the wall, radiators were not all covered and water temperatures were not all within range. We found during this inspection that these concerns had not been addressed. There was no action plan to show what action would be taken to improve these areas or who would address them.

We also viewed completed kitchen audits and these identified the same issues for the past three months. We found that some of these issues had been addressed but this was not reflected in the audit. Actions identified through care file audits had also not been addressed within the time frame the action plan stated. We also viewed audits in relation to medicines and these identified the issues we highlighted during the inspection, such as thickening agents not being signed for. The registered manager told us as they had not been in post for long, they had not been able to address all of the concerns they had identified through the audit process, but was aware of the areas that required improvement.

Issues identified through an external service risk assessment had not all been addressed by the provider. For instance, the audit highlighted that the door which led to a staircase to a staff only area should be kept locked at all times. We found during the inspection that the door was not locked. This meant that vulnerable people could access areas of the home that could pose risks to them.

This meant that although systems were in place to monitor the quality and safety of the service, action was not always taken to address the identified concerns.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider made regular visits to the home and had last undertaken a formal review of the service in October 2016 and reviewed areas such as the environment, care plans, staff rotas and maintenance checks. They also spoke with staff and people living in the home. They had a good awareness of the areas that need improving from these visits. Records showed that the care quality manager had been visiting the service regularly and completing themed inspections but these had not been completed for a number of months. At the time of the inspection the care quality manager was based within the home to support the registered manager to make the necessary improvements. The care quality manager explained that they had not

completed their usual audit schedule as they were currently based at the home and involved in the daily checks and monitoring, so had a good understanding of areas that required improvement and was supporting the registered manager to address all of the areas of concern that had been identified.

The home had a registered manager in post. The registered manager registered with the Care Quality Commission in November 2016 and prior to that there was no registered manager in place for a number of months. We asked people their views of how the home was managed and feedback was positive. All people we spoke with told us how the home had improved since the new registered manager had commenced in post. People described the registered manager as, "Approachable", "Very nice" and, "Quite friendly." A relative told us, "The new manager has grabbed hold of things and is getting things done."

Staff we spoke with told us they felt much more supported now and more settled. One staff member described the registered manager as, "Brilliant" and that they could go to them for anything at all. Staff told us they enjoyed working at the home and one staff member told us, "I love my job." Staff described Broadway Nursing as a happy home and all staff told us that they worked well together as a team to meet the responsibilities of their roles and the values of the service.

The provider had policies and procedures in place to guide and inform staff on all aspects of their role. These policies had recently been reviewed and updated where necessary and the registered manager had implemented a form for staff to sign when they had read the updated policies. This was underway and a number had been signed by staff. Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

Staff we spoke with told us they had regular team meetings and felt able to share their views during these meetings and that they were listened to. We viewed records from these meetings. We asked staff to share examples of how improvements had been made based on their suggestions or feedback. One member of staff told us the menu had recently been changed due to feedback from people living at the home and another staff member told us an employee of the month scheme had been introduced after they suggested it. This showed that staff were listened to and changes made based on their feedback of the service.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risk regarding Broadway Nursing.

The rating from the previous inspection was on display within the home in line with requirements.

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 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The environment was not maintained to ensure people's safety. Chemicals were stored securely, not all fire doors had been adequately maintained and water temperatures were not within safe ranges. Medicines were not always managed safely. |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Confidential records were not always stored securely. Care plans did not always reflect current care needs, were not all detailed and some lacked personalised information. There was limited evidence of involvement in care plans. |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing |
| Treatment of disease, disorder or injury | Supervisions and appraisals were not completed regularly. Not all staff had completed safeguarding or medicine training. |