Broome End Ltd

Broome End

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?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on the 16 July 2015 and was unannounced. This service was inspected because of a number of concerns we received about the service. We visited to ensure that the needs of the people using the service were being met and people were safe. The report focuses on the concerns and not all the key lines of enquiry we inspect against were looked at in much detail. We have given the service a rating but will choose to re-inspect the service again to check out the rating.

The service was last inspected on the 07 April 2014 and was meeting all the required standards of care.

The service is registered for Accommodation for persons who require nursing or personal care and can accommodate up to 37 people. The service had a registered manager in post at the time of our inspection.

'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.'

Summary of findings

During this inspection we identified some risks to people's health and safety including safety certificates which had lapsed in relation to legionnaires testing. This has since been addressed.

Most people were supported to eat and drink enough for their needs but some people needed additional monitoring and encouragement to ensure this happened. Records did not always reflect the fact that people are adequately supported in terms of their health needs.

During this inspection we found there to be enough staff to meet people's needs. However this fluctuated according to levels of staff sickness and the ability to get agency cover. Staff recruitment was on-going.

Staff knew how to raise concerns and had received training in protecting adults.

There were systems in place to ensure people received their medicines safely and staff that were competence to give medicines.

Staff were effectively supported and received the training they required for their job role so they had the necessary skills. There were adequate recruitment processes in place.

People were supported to make appropriate decisions about their health and welfare.

Some poor practices were observed around lunch time in the small dining room where people's independence and dignity were not upheld. The dining experience in the main dining room was observed as caring and pleasant.

People were involved in their care and asked to contribute to decisions about their care and welfare.

People were given opportunities to partake in a range of activities around their individual interests and hobbies, including trips to the local community.

People's needs were assessed and records were comprehensive and mostly up to date. They gave us a good insight into people's needs and how they were being met. We identified some minor gaps in terms of records and not always being up to date when people's needs had changed.

We did not look at complaints but saw there was an established complaints procedure.

The service had continuity of management and audits took place to assess the safety and suitability of the service being provided.

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 mostly safe.

We identified a number of potential risks to people's safety as records were not completely up to date and some maintenance had lapsed.

There were enough staff to meet people's assessed needs.

Staff recruitment processes were adequate.

Requires improvement

Is the service effective?
The service was effective

Staff received appropriate support and training for their job role. They were able to deliver care effectively.

People were supported and asked to make decisions in relation to their care needs and how they would like these to be met.

People were mostly supported to eat and drink enough for their needs. This was documented and referrals to other health care agencies were made when appropriate. However we identified variable practice

The home monitored people's health and made referral when appropriate when there was a decline in the person's health. However because records were not always up to date this was sometimes difficult to see.

Requires improvement

Is the service caring?
The service was caring.

Most staff interactions observed were compassionate and caring. People's dignity was mostly upheld but we did identify one example of poor practice.

People were supported and given choices in their day to day lives. There was information in the service to help people make choices

Good

Is the service responsive?
The service was responsive.

Staff knew people well and responded to their needs.

Activities were provided both individually and on a group basis for those that wanted them.

Care plans were robust but were not completely up to date.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

There was a registered manager in place who was supported by the provider and senior staff. Staff told us they were well supported.

There was a lot of information around the home which helped people and visitors know what to do if they were not happy with any aspect of the service or needed specific support around their needs.

The service had adequate monitoring systems to ensure people's needs were met. Gaps in record keeping were being identified.

Broome End

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.'

The inspection took place on the 16 July 2015 and was unannounced. We carried out this inspection because of concerns raised with us in relation to the care provided. The inspection was carried out by two inspectors.

As part of this inspection we observed the care being provided, We used the Short Observational Framework for Inspection (SOFI).SOFI is a specific way of observing care to help us

Understand the experience of people who could not talk with us.

We spoke with seven staff including the senior, care staff, activity and maintenance staff. We spoke with the manager and provider. We also met with four visitors, a visiting professional and spoke with five people using the service. For the most part we used observations of care to tell us about people's experiences. We looked at three care plans, and other records relating to the care people received and the management of the business.

Requires improvement

Is the service safe?

Our findings

Prior to this inspection we were alerted to a number of concerns which had been raised, investigated and substantiated by the Local Authority. These related to people not always receiving care appropriate to their needs. One related to no access to water as the supply had accidently been turned off. As part of this inspection we found improvements had been made and there was a robust action plan in place. The manager was being supported by the quality assurance team from the Local Authority. Despite these improvements we still identified some concerns. These included gaps in recording and risk assessments not being as robust as they could be.

We noted that the provider had not carried out a test for legionnaires on the water storage tanks for over a year. The requirement is at least annually. This put people at an increased risk of contracting legionnaire's disease. Since the inspection this was quickly rectified and all other health and safety certificates were up to date.

We spoke with the maintenance person about how they maintained equipment to ensure people were safe. They kept a log of routine maintenance and refurbishment they had carried out. This was satisfactory. However we saw an email which confirmed problems with the lift. On the day of the inspection we were informed by staff that the lift was not working and had not been since the weekend. A sign of the lift door told us not to use it. Staff told us this meant that people who usually came downstairs for their meals and activities were unable to and were not able to access the garden. We asked the provider about the lift as we would have expected to be notified of this as it was an event affecting the smooth running of the service. They told us the lift was working but was unreliable. Following the inspection the provider notified us that the lift had been serviced and was now fully functioning ten days after it first broke down.

Staff told us they provided good, safe care. One relative told us their family member took dietary supplements and had put on weight. They said their family member were at risk of falls but staff regularly monitored them, there was an adjustable bed in place which could be lowered and a floor sensor so staff were alerted when they were mobilising. This they said helped to reduce the risks to their family member's safety.

We looked at people's falls risk assessments and saw these were not automatically updated after a person had a fall. This meant we could not always see from records if appropriate actions were taken.

People's weights were monitored but we saw some weights had not been done for June. Where people were not able to be weighed a malnutrition universal screening tool, (MUST) was in place. This used other measurements to establish people's risk of malnutrition. There was guidance on how to use this tool and staff were completing it correctly. People at risk of dehydration were identified and staff were told to push fluids. However there was no fluid target set for people which would make it more difficult for staff to know when people were not drinking enough.

A visiting health care professional expressed concern about a person who was still in bed just before lunch and had not had much fluids People's fluid intake were being regularly checked by the manager.

Risks to people's safety were documented and risk assessments which included an action plan and were kept under review. For example we saw steps had been taken to protect people most at risks of falls and equipment such as bedrails, or crash mats were in place where identified as necessary. People's weights were monitored and food and fluid intake more closely monitored where people were at risk of not eating or drinking enough for their needs. We saw that staff referred to other health care professionals in the management of risk. The dietician had reviewed and provided guidance to staff for people losing weight. In people's rooms was a record of the care they had received and who had provided it which meant staff could be held accountable.

Whilst looking round the service we found personal toiletries including a razor left in an open bathroom which could be a hazard to people's safety. We also found the top floor to be very hot and staff had a number of fans to try and keep the area cool. There were no risk assessments in place to take into account the lift was broken and this could affect some people's safety.

Some months before our inspection the home had an infection outbreak and had taken sensible precautions to stop the spread of infection by improved hygiene practices. All the staff had been informed and there was guidance made available to staff. Around the home we noted gloves,

Requires improvement

Is the service safe?

aprons and hand gel to be used to stop the spread of infection. We saw staff following good infection control practices and staff were knowledgeable about infection control procedures.

This meant sensible precautions were in place to stop the spread of infection.

We spoke with a number of relatives who said they felt their family members were well cared for and risks to their health and safety mitigated as far as possible. Most people were not able to tell us about their experiences but we saw that people were kept safe by staff. Staff carefully explained what they were doing and reassured people if they became anxious.

Staff spoken with understood safeguarding procedures and who they should report to if they suspected a person to be at risk of abuse or harm. Staff received training in the protection of adults and there was a policy for staff to follow. Staff understood whistleblowing and said they would escalate concerns if required. There was a lot of information in the service to tell staff and people using the service how to raise concerns including a flow chart which showed how to escalate concerns. Main doors were key coded for people's safety. However we could not see how people could go outside unless they asked, however people had patio areas and rooms overlooking the garden.

Staff told us they were confident in the management team and felt any concerns they raised would be addressed. Staff also told us what actions had been implemented as a result of recent safeguarding's and said there was increased monitoring and vigilance in terms of documenting people's needs.

On the day of our inspection there were enough staff to meet people's needs and the manager was proactive in monitoring people's needs and trying to get additional funding for staffing where people required extra support. Staffing levels were only compromised when the manager was unable to get agency staff at short notice such as when staff called in sick at short notice. They told us there was a policy around managing staff sickness and they sometimes stepped in to cover shifts or staff picked up overtime. Before the inspection we received concerns that staffing levels were not always sufficient to meet people's assessed needs and by their own admission sometimes they found it difficult to cover the shifts.

There were a number of vacancies in the home which were being recruited too. We looked at the staffing rotas and it matched the number of staff it said it needed.

We asked staff about the use of agency staff. One staff member told us if agency staff are used it is only one at a time so it does not interfere with the smooth running of the home. They said seniors were very good and it was a cohesive staff team.

Another staff member said they had now started to use more than one recruitment agency and whenever possible would book early. They said staff sickness levels could compromise the service. A staff member said that an additional member of staff had been employed to help with one person who needed one to one support and this had helped other staff.

Throughout the day people's alarms went off frequently but were answered quickly by staff so people were not kept waiting. There were a number of people in their rooms and they had their alarm bell next to them. We saw that one person could not reach their call bells but saw from records in their room they had been monitored regularly. We also saw in another's person's room a photograph of how to use the call bell to help the person.

We briefly looked at staff recruitment and saw processes were satisfactory with proof of the persons suitability and eligibility to work in the country and current disclosure and barring check, (DBS) and independent safeguarding authority (ISA check.) For one person we found only one reference in situ when the expected standard is two. The provider told us there were stringent recruitment processes in place and staff would not start until all the required documentation was in place.

There were adequate systems in place to ensure people received their medicines safely. We spoke with one person who told us they were giddy on waking and were given their tablets first thing to counteract this. Another person had said they could take their own medicines safely. Their views had been recorded. This had been formally assessed and a decision reached that staff needed to administer medicines because the person would not be able to do this safely.

One person told us they could have pain killers when they needed them and staff asked them regularly to ensure they received medicines as they required them.

Requires improvement

Is the service safe?

Staff told us they received medicine training and regular updates. We saw further evidence of this from the staff training matrix which included staff competency assessments.

We observed staff administering medicines. Staff asked if people needed medicine to relieve pain and respected their decision. Medicine was administered then records signed. The medicine trolley was made safe and secure when staff left to administer medicines. Medicine recording sheets were complete and used coding where necessary to show why medicines were not administered such as not required or refused. This meant medicine could be properly accounted for. Controlled medicine was appropriately stored and two staff signed when administering this medication. A running total of this type of medicine was kept to ensure they met the legal requirements of handling this medicine.

We saw a record of topical creams being applied and codes being used did not tally with the codes on the medicine record so this was a bit confusing. We noted creams were dated when opened so staff would know when to discard medicines after the best before date

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Requires improvement

Is the service effective?

Our findings

We spoke with a senior staff who was very supportive of their staff and told us staff received regular supervisions, each month and each senior had a number of staff they would supervise. They told us they did observations of staff practice and any concerns of poor practice were addressed immediately and in supervision. The senior said they had completed relevant training in the management of staff.

Staff told us that their induction was thorough and they were shadowed by more experienced staff before working independently and then received all the required training within the first three months of employment.

The senior member of staff said training was up to date and the home had a number of train the trainers and did training in house. We asked if staff did specific training on meeting the needs of people living with dementia. The senior said they had recently done some training called a 'virtual dementia tour' which enabled staff to experience what it might be like to live with dementia.

We spoke with staff about their training; one said the dementia training was amazing. Staff said their training was up to date and they always got a lot of support.

We saw people had signed their consent for medical treatment such as flu vaccinations. There was a lot of information in the home around consent and capacity and staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We saw for one person that did not want to be at the home but were unable to live independently that they had been seen by the GP who had helped staff to implement strategies to support this person. Their family members had enduring power of attorney for their health and welfare and this was documented. It recorded that they had a lack of insight but could make day to day decisions. Staff supported them to go out safely.

We observed lunch being provided in two separate areas of the home to see if people had enough to eat and drink for their needs. Family members told us the food was good and varied. This was reflected by our observations. Staff spoken with were aware of people's individual dietary requirements and any special diets. People were given appropriate choice according to their needs and requirements.

Our observations of lunch provided in the downstairs dining room were positive with people being gently encouraged to eat their food and giving appropriate, timely support. We also observed staff giving people meaningful choices and accommodating their individual dietary needs. The meal time experience for people upstairs was less satisfactory with people not getting individualised care and support.

We noted throughout the day that people in their rooms did not get as much encouragement to eat their meals and we saw several people that had left their food and gone back to sleep. We could not be assured their dietary needs were being met.

There was a concern about one person who was seeing the district nurse and had a pressure sore. On the morning of our visit we saw that they had refused meals the previous day and had not drank much that morning. Staff were monitoring them and trying to encourage them to eat and drink. Staff told us in relation to another person some days they are more inclined to eat and on those days they have lots of snacks and drinks which compensate for the days they don't drink so much.

We observed staff encouraging people to drink throughout the morning. However fluid records showed variable amounts for people. Drinks were regularly brought round to people but we observed one person who would be unable to reach their drink. In recent months a number of safeguarding's had been raised about the well- being and, or safety of a number of people using the service. For one person they had been in and out of hospital and had an underlying health care condition which compromised their health. The manager was very knowledgeable about this person and told us what systems they had put in place to ensure people were adequately hydrated. This included increased vigilance by the manager and checking people's food and fluid records three times a day to see they were getting enough to drink. The senior told us night staff then added up fluid quantities and raised a concern with staff and other health care professionals if people were not getting enough fluid. They said they do this within twenty-four hours. This meant the home had implemented changes as a result of concerns raised to ensure people's needs were being met. However we felt people could still be at risk due to variable practices throughout the home.

When we asked staff about people's needs they were very knowledgeable and were able to tell us about how needs

Requires improvement

Is the service effective?

had been identified and addressed by a range of different health care professionals. We looked at one person's record and found the information difficult to follow. It said the person required a soft diet but in fact had been given toast all be it cut up into squares. The reason for a soft diet was not because of risk of chocking but more around their anxiety and sometimes unwillingness to chew. This information was not clearly captured in their care plan. There was information from the speech and language team but this was at the point of admission and had not been reviewed. There was nothing recorded about this persons anxiety or a mental health care plan.

Staff told us they had good contact with health care professionals and used three GP practices with at least a weekly visit from the community matron and a monthly visit from the GP and as required. The manager was also proactive in getting people's needs reviewed and trying to secure additional funding where appropriate to enable them to continue to meet the person's health care needs within the home.

One person told us they had seen the chiropodist recently and could see the GP. They told us they had a skin complaint and this was kept under review and staff applied creams.

People told us they saw the community matron, district nurses and the GP where required. Changes to people's needs such as skin tears, and changes to the condition of a person's skin were recorded with what actions staff had taken to address this such as apply cream or refer to the district nurses.

People records showed that people saw medical health care professionals as required and there was evidence that people had been seen by dentists, opticians and the chiropodist.

Good

Is the service caring?

Our findings

We spoke with relatives, they told us, “Staff are very good, very kind. When we phone they are the same, very kind. They never get cross.” Visitors and family members all told us that the staff at the home were kind and helpful. One person when asked said, “Yes its lovely, its fine here.” Another said, “staff are lovely, very kind.”

People had life stories which were very good as they divided the person’s life experiences up starting from childhood, adolescent, middle age and later years. This helped staff develop positive, caring relationships with people based on their experiences. Care plans were very informative and we saw that care plans reflected people’s choices and preferences. However we saw for one person who had recently moved to the home their life history was very limited which might make it more difficult to help them settle in and know what their preferred routines were.

One person was hard of hearing; their care plan stated they should wear their hearing aid. We found they were not and the manager told us they refused to wear it. This information had not been updated in their care plan. However we saw that staff had given them a white board for them to use to communicate and this was done effectively.

One person asked if they could go outside, the carer said, “It’s too cold, I will take you into the conservatory.” This meant the person’s wishes were not met, it was not cold outside.

We observed carers with one person who was unable to see, staff were tactile with her and helping them feel safe through touch and reassurance. We observed staff supporting people whilst moving them from bed to chair and chair to chair. This was done sensitively and safely and staff demonstrated good manual handling practices. Eye contact was maintained through interactions and staff showed good communication skills and empathy.

We saw some incredibly kind, caring interactions between staff and people using the service and felt on the whole people’s dignity was upheld. We observed people on the ground floor dining room being supported positively with their meals. However we identified some very poor practice upstairs in the small dining room. People were being assisted with their meal and staff were rushed and did not maintain people's dignity. The carers told us that there were not usually so many people upstairs and they were not always this busy but said this was because the lift was broken and had been since Sunday. This was seen as a isolated practice and brought to the providers attention for them to address.

People were supported and staff gave people choices in a way which were meaningful to them. Records documented people’s choices and preferences in care and we saw evidence of consultation with people, their families and other health care professionals to help ensure care was met as comprehensively as possible. There were mechanisms in place to support people to provide feedback about their experiences through meetings, reviews an established complaints/compliment procedure and quality assurance system which asked for people’s views so any shortcomings could be addressed.

Good

Is the service responsive?

Our findings

Two relatives told us, "Yes they get on well here, they get their needs met and their health is okay." They said their family member had lost weight but that staff had responded and they now had put weight back on and had regular supplements. They said staff kept them informed of any changes to their family member's health and they were confident in the staff and the care they provided. They spoke about the range of activities in the home but said their relative did not usually take advantage of the trips out.

In the main lounge we noted a small group of people engaged in activity. There was an activities coordinator who told us they were soon leaving and their post had already been recruited to. They worked twenty four hours a week which they felt was insufficient to adequately meet everyone's needs. However we saw that they work tirelessly throughout the day and gave people time and positive attention which they might not of over wise received as carers were busy until lunch time assisting people up. The activities coordinator told us they usually spent the morning planning and writing up records and providing one to one activities and in the afternoon providing group activities. People told us about their recent trip to Woburn Abbey and we learnt that a small group of people regularly went out in the homes transport each month. People paid for their own trips. Staff told us they were sometimes accompanied by family members.

The activities coordinator said they had enough resources and had different activities planned throughout the year, using external entertainers. Some people were looking at brochures and sparkle box which is a magazine about old times and used as part of reminiscence.

The activities person told us that although most of their hours were during the day they did also work in the evening depending on what people wanted. They said, "People do not go to bed early and sometimes activities are planned for this time."

The hairdresser visited every week and people were well dressed with smart appearance.

Care staff working upstairs told us that some people upstairs whose needs were greater did not always have the opportunity to join in activities. The provider told us that whatever people needed they would purchase and this included things to keep people occupied. We did not observe staff supporting the activities coordinator or engaging people throughout the morning in different tasks.

We noted one person sat for the entire morning without any engagement from staff. We were told this person did not want to be there and was very unhappy and thus got quite angry with the staff. However we felt this persons experience could have been enhanced if staff continued to engage with them and provide them with meaningful support.

One person asked for the toilet and needed help from staff as they required a hoist. Staff were immediately attentive but they had to wait until a hoist became available. The senior told us they had several hoists but we observed a hoist being taken from one floor to the other and wondered if a hoist on each floor would be appropriate depending on the needs of people using the service.

One person told us they had not seen their care plan, but had been asked about their needs and said staff always asked them if they needed anything else. Staff spoken with told us about people's needs and how they were meeting them. What they told us reflected what was recorded in the person's plan of care.

Staff knew people's needs well. We saw one person was still in bed and staff said they did not get them up until 11. They told us their skin got sore so they tried as often as possible to change their position. This included transfers from bed to easy chair. Their chart showed two hourly turns. Staff said they had all the equipment necessary to assist this person with their manual handling needs. There were records in people's room including daily notes of care of what had been given such as a bath, a wash, and how often they had been repositioned. Guidance was in place for staff about how to support people with their manual handling needs. An accountability sheet in people's rooms showed who provided the care.

A staff member said one of the strengths of the service was the level of detail in the care plans. They told us, "They really help you get to know the needs of people using the service." We also saw handovers which took place between shifts so information was shared to promote continuity of care.

We looked at a number of people's care records and found them to be comprehensive. People were not admitted to

Good

Is the service responsive?

the home until their needs had been assessed to ensure the needs could be met within the home. We noted care assessments were not always carried out by the most senior member of staff and wondered if the staff carrying out the assessment had the appropriate skill to do so. People needs had been reviewed and we saw changes in people's health had been flagged up and addressed.

Information for people recently admitted to the home was comprehensive although their life stories were still being developed. People's records included a needs assessment and evidence that their needs had been reviewed after two weeks following admission with the view of them becoming a permanent resident. Their records had been reviewed but not for the month of June. Other care plans had not been updated since May. Staff told us they should be reviewed monthly and this had lapsed which meant they were not up to date.

We did not see any complaints but saw there was an established complaints procedure which was clearly displayed and accessible to all.

Good

Is the service well-led?

Our findings

Staff spoken with said the manager was very supportive and approachable and felt the home was well led. When we spoke with the manager it was clear she was hands on and often provided direct care herself. She knew both staff and people using the service very well and had acted upon recent concerns about the care provided to a number of individuals in the home.

We spent time talking to the provider who was at the home two or three times a week. They told us they had bought the home about two years ago and had worked hard refurbishing the service and bringing the environment up to scratch. They chaired a planned staff meeting in the afternoon. Staff knew the provider and were able to raise issues at the meeting which were documented. One staff member felt the provider was not approachable but this was not the experience of the majority of the staff. Following our inspection we gave feedback to the provider about the undignified care practices we had observed. We suggested observations of care be formally introduced to identify and stamp out poor practices. The provider had agreed that additional training for all staff would be advantageous and has already outlined actions they will take to ensure pockets of poor practice are addressed. .

The home were involved in the PROSPER project which was provided through the local authority and aimed to promote safer care in care homes. Funding has been provided for two years to work with homes to improve safety, reduce harm and a reduction of emergency admissions primarily as a result of falls, pressure ulcers and catheter infections. We saw some documentation relating to this project. A safety cross indicated risk factors from falls and staff could see at a glance who was most at risk. We looked at fall audits but this had not been completed for June. Accident/ incident records told us what actions had been taken to manage the risk which meant factors affecting the well-being and, or safety of people using the service was monitored. The provider had employed additional senior staff to assist the manager and to oversee high standards of care, which included a review of the records to ensure they accurately reflected the care provided.

There was a lot of information in the main reception to help both visitors to the home and people using the service. Information included how to raise a complaint/ compliment, Mental capacity, details of advocacy, information about the service and the last inspection report. We also saw what was going on in the home with photographs of different activities and a white board advertising the day menu choices. A photo-board showed which staff were on duty that day. This meant visitors to the home could see who was supporting their relative and people were given information about their day to day care and what they could expect from the service.

The maintenance person was full time and told us about the schedule for maintenance and servicing of all equipment and procedures around fire safety and fire drills. The fire procedures were clearly displayed.

We saw evidence of staff surveys to establish if staff felt well supported and that they had all they needed to do their role effectively. Staff raised concerns about staff leaving but generally were happy. We did not look at other quality assurance processes but were advised that they were in place to ascertain people's views on the service. Meetings were held with individuals rather than group residents meetings as this was felt to be more productive. We saw that people were given information to help them.

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.