Ashberry Healthcare Limited

Broomy Hill Nursing Home

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Broomy Hill Nursing Home is a residential care home providing personal and nursing care for up to 40 people aged 65 and over, some of whom may live with dementia or mental health support needs. At the time of the inspection 25 people were living at the home.

The home has several communal areas including a garden and dining facilities. At the time of the inspection some refurbishment had been completed. Refurbishment was on-going in other areas of the home.

People's experience of using this service and what we found
People were not always supported to have their medicines as prescribed. This increased the risk people would not have the medicines they needed to remain well. There continued to be no record of daily checks to confirm people's pain medicine patches remained in place. This increased the risk people may experience pain.

People's risks and care needs had not consistently been identified and their risks managed. This included in relation to people's skin health and risk of choking. The provider's representative agreed to review how they deployed staff at busy times, so people did not experience delays if they required support and encouragement at mealtimes.

Key areas of the premises required the completion of refurbishment, to ensure the likelihood of the spread of infection was reduced and to ensure effective fire management practice. Lack of effective staff and provider oversight of incidents such as medication errors reduced the likelihood of learning lessons when things went wrong.

Risks to people's health had not been consistently identified and action had not always been promptly taken to advocate with external health professionals so people would get the care they needed. The introduction of a robust system for monitoring peoples nutritional and hydration needs was required to ensure people consistently achieved good health outcomes.

People were not always supported by staff who had received training relevant to their needs, and the provider could not be sure staff had the competency required to support people to have their medicines safely.

The views of external professionals were not always promptly obtained when decisions were taken in people's best interests. This increased the risk people's rights would not be respected. Systems for communicating information about conditions on people's DoLS authorisations was not readily available to the manager, or to guide staff to promote people's rights.

The provider had failed to ensure there was adequate oversight of the care provided at the home. Quality

assurance processes had not fully addressed previous breaches and had not identified concerns we found during this inspection. At this inspection we found the service failed to display the most recent CQC inspection rating at the home.

Systems which the provider had recently introduced did not always provide staff with a full overview of the needs, risks and care people required. The provider had not put robust systems in place to ensure staff roles and responsibilities were consistently clear or to maximise opportunities for developing people's care further. A new manager had recently been appointed at the home. They told us they intended to apply to CQC to become the registered manager. Changes to the staff representing the provider were also planned.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update:
The last rating for this service was requires improvement (published 19 June 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 20 April 2021 and 21 April 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective and Well-led which contain those requirements.

We had also received concerns in relation to people's safety, staffing and governance.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to how people's safety and risks are managed and how the home is

managed at this inspection.

Please refer to the end of this report for our full regulatory action taken.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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. Details are in our effective findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Broomy Hill Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) and 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors and a specialist advisor in nursing.

Service and service type
Broomy Hill Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The provider, who is legally responsible for how the service is run and for the quality and safety of the care provided, had recently recruited a new manager.

Notice of inspection
The first day of the inspection was unannounced. The second day of the inspection was announced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the provider. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took

this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spent time seeing how people were cared for. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 15 members of staff including the manager, two provider representatives, the nominated individual, nurses, senior staff, care workers, and a member of catering staff.

We reviewed a range of records. This included eight people's care records and multiple medication records. We also checked nursing registration documents. We looked at records relating to the management of the service and people's safety. These included audits and checks undertaken by the provider's representatives and other external stakeholders, staff competency checks and medicines management. We also checked premises improvement plans and risk assessments, mattress audits and people's personal emergency evacuation plans, plus fire management records.

We checked records showing how staff communicated people's changing needs, including staff meeting minutes and daily handovers.

After the inspection
We continued to seek assurances from the nominated individual, manager and provider's representatives to ensure people's immediate safety needs were met.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Requires Improvement.

At this inspection this key question remains requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider had failed to safely administer people's medicines and to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Using medicines safely

- Systems and practices did not consistently support people to have their medicines at the times prescribed. One person had experienced delays of between forty-four minutes and up to one hour and thirty-one minutes on the records we sampled.
- No record was in place to confirm staff had checked people's pain medication patches remained in place. Such checks are important, as people are at risk of experiencing unnecessary pain if medication patches are not in place, where prescribed.
- There were suitable containers to hold waste materials such as used needles and other sharp tools, which could puncture human skin. There were two containers in use. One container was not signed and dated when it was brought into use. The second container was not signed and dated when it was brought into use and it was not signed to confirm closure. Incorrect management of sharp items could increase the risk of injury to staff and the spread of infection to people living at the home.

Assessing risk, safety monitoring and management

- People's risks and care needs had been identified by staff, but we continued to find inconsistencies in how this information was communicated to all staff and how people's risks were managed. For example, we found one person had a steady decline in weight, with their weight loss recorded as 8.5 Kg between 04 July 2021 and 06 September 2021. A care review was undertaken on 06 September 2021, where it was highlighted this concern needed to be escalated to the person's GP. A senior staff member we spoke with was not aware of this and could find no evidence that this had been actioned. The provider's representatives advised us the weight loss had been escalated to the person's GP, but not followed up after the initial referral. We requested the person's GP was contacted as a matter of urgency.
- People who were at risk of poor skin health were not consistently supported through practices which reduced their risks. We found one person had been identified as having poor skin health. No skin care plan had been put in place to guide staff on how to care for the person. A senior staff member was not aware of the person's skin health needs. Staff told us another person required repositioning every two hours, to

reduce the risk of them experiencing poor skin health. We found over an eight-day period the interval between the person being repositioned ranged from 4 hours and 22 minutes to 19 hours and 35 minutes. Systems for alerting staff to reposition the person were not working effectively.
● Some people were prescribed thickener, to reduce the risk of choking. Information senior staff had provided to staff on people's individual thickener needs was not consistent. This increased the risk people may not be given the level of thicker they needed to reduce the risk of them choking.
● Aspects of the management of the premises required improvement, in order to reduce risks to people further. For example, the storage of accelerants and combustible materials. Staff had also been provided with inconsistent information on the level of support people would require in the event of the need to evacuate the home as a result of a fire.

Staffing and recruitment
● The provider's representatives had put a staffing dependency tool in place, to inform decisions about staffing levels. However, this had not been updated since July 2021, in line with people's changing needs.
● Staff told us there had been times when they were busy, particularly during a recent COVID-19 outbreak, however, there was no expectation they would work additional shifts if they did not wish to do so.
● There was sufficient staff to assist people promptly, should people require support in an emergency, but some people experienced extended waiting times for support from staff at busy times. This included during the lunch time service on 13 September 2021.
● The provider's representative agreed to review deployment of staff and their dependency tool to address concerns people may experience delays during routine care.

Preventing and controlling infection
● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. The home environment presented as clean, however, the home was undergoing refurbishment. Some controls to reduce the risk of the spread of infection were not working effectively. For example, porous surfaces around people's bedroom doors required maintenance.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There had recently been a COVID-19 outbreak at the home. The contingency plans in place had not ensured sufficient staffing and management oversight without support from external agencies.

Learning lessons when things go wrong
● Lack of effective oversight from the management team at the home and the provider reduced the likelihood of learning lessons when things went wrong. For example, we found a person had been administered their medication two days earlier than prescribed. Whilst there was no indication of harm to the person, systems were not working robustly enough for staff to identify or escalate this to the management team, so any lessons would be learnt.

Systems were either not in place or robust enough to demonstrate safety was effectively managed, concerns promptly identified and risk to people swiftly mitigated. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider's representatives responded to these concerns during and after the inspection. They confirmed all the actions required to keep people safe were now completed.

● We found improvements had been made in the way people's allergies were recorded, their medicines

stored, and staff access to information to support the safe administration of 'as required' medication.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● The provider was not admitting new people to the home at the time of the inspection. Systems were in place to reduce the risk of the spread of infection when new admissions recommenced.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse
● People were supported by staff who understood what signs to look for which may indicate abuse may have occurred.
● Staff were confident if they raised any concerns for people's senior staff would escalate these and take action to protect people.
● The provider had safeguarding policies and procedures in place for reporting any safeguarding concerns to the local authority.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's assessments did not always identify all their care needs. These included in relation to how much fluid people required to remain well and consistent assessment of people's skin integrity. This increased the risk people would not receive the care and support they required.
- In other instances, some people's needs had been identified and plans put in place to support them. For example, in respect of falls, mobility and moving and handling and choking risks. These were reviewed monthly.

Supporting people to eat and drink enough to maintain a balanced diet

- Staff had assessed if people required support to have enough to drink, but practice did not consistently promote good hydration. For example, one person remained in their room due to illness. The person had a jug of fluids in their room and a beaker of cordial. On 13 September 2021 at 13:25 pm we saw there was 100 mls of fluid in the jug and approximately 50 mls in a beaker. The jug was dated "11 September". We checked throughout the afternoon and saw the same amount of fluids remained in place. No fluids were in the person's room on 14 September 2021.
- In addition, people were not offered a choice of drinks during their lunch time meal on 13 September 2021.
- We checked the fluid records for five people who were at risk of dehydration. Daily targets had not always been set to guide staff on how much fluid intake to promote. Where fluid intake was recorded, this ranged from a daily intake of 150 mls to 1128ml; the averages recorded were not sufficient to assure us people were receiving good hydration and would remain well.
- Where people were able to requests drinks from staff we saw their requests were responded to.
- People's nutritional needs were not consistently promoted through deployment of staff to encourage people to have enough to eat, or by offering people alternative choices. For example, one person had declined to eat a number of meals and snacks offered to them over two consecutive days. Staff told us the person regularly declined meals, and then their appetite returned. There was no record of this in the person's care plan, or instructions to guide staff to promote good nutritional intake through encouragement, including by offering the person choices based on their known preferences.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received training relevant to their needs. For example, not all staff had received training or awareness guidance on Parkinson's disease. In addition, not all relevant staff had received training in how to clean and care for some specific clinical equipment, such as devises to

assist people to have the nutrition and medicines they needed to remain well.
● Staff told us about the training they had recently undertaken including care control, (a care recording system), however, this needed further time to embed. For example, not all staff currently had the skills to check on people's nutritional intake or other clinical histories. This increased the risk people would not receive the care they required.
● Senior staff had attended medicines management training and their competency to administer medicines was checked annually. The competency assessments were not robustly carried out. Of those sampled, two staff had no evidence of supervised or practical assessments being carried out. Two staff had three elements of the assessment which had not been completed, but it was recorded they passed their assessment. A further staff member's assessment was recorded as "partially passed more guidance and training to be given". However, the staff member's assessment had been recorded as passed. There was no evidence that further training had been carried out. The provider and manager could not be assured staff had the skills to manage people's medicines safely.
● After the inspection the manager and provider's representative gave us assurances action had been taken to address these concerns.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Evidence was not always available to confirm people's health needs had been promptly followed up after referral to external professionals, so people's health needs would be met. This included in relation to people's weight loss. However, other people were supported to see external specialists, such as chiropodists, opticians, mental health teams, occupational therapists and speech and language therapists, as required.
● Staff told us they were confident handovers at the start and end of each shift provided them with the information they needed to meet people's changing health needs. We found staff had not always been alerted to changes in people's health needs which would require support. For example, when staff returned from planned absences at work.
● There had been improvements in the frequency people's weights were checked. However, there was not an effective system in place to ensure people's weights were accurately recorded, or to consistently and promptly obtain specialist advice from external health professionals in the event of changes in people's weight.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● There remained an inconsistent approach to involving external professionals when decisions were taken

in people's best interests. In some instances, decisions had been taken on a temporary basis to administer people's medicines covertly. These decisions had been referred to external professionals for consultation, however, we found these were not consistently followed up in a timely way. This meant temporary best interest decisions remained in place for extended periods, for example, for in excess of four months for one person. This approach increased the risk people's rights would not be respected.

● For other decisions taken in people's best interests, relatives and other professionals such as GPs and pharmacists had been consulted and involved in best interest decisions.

● Information to confirm if the supervisory body had applied conditions to people's DoLS authorisations was not readily available to the manager, or to guide staff. The manager and provider gave us assurances after the inspection this was now in place.

● Staff listened to people's decisions about where they wanted to spend their time and what they wanted to do.

Adapting service, design, decoration to meet people's needs

● Areas of the home were in the process of being refurbished. This had been suspended during a recent COVID-19 outbreak. The provider was aware further progression of the refurbishment was required to ensure people's independence was promoted through adequate signage, particularly to assist people to locate their bedrooms.

● Improvements had been made to some bathroom facilities for people's use.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to have effective governance systems in place to assess and monitor the quality of the service to identify shortfall and to ensure compliance with regulations. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to ensure there was adequate oversight of the care provided at the home. Quality assurance systems and processes had not identified or addressed concerns found during the previous or current inspection.
- Systems and processes in place were ineffective. Known risks to people in relation to their fluid intake and repositioning needs were not adequately monitored, which left people at risk. The electronic care monitoring system which the provider had recently introduced did not provide the manager or provider's representatives with a full overview of the needs and risks of the people being cared for. For example, there was an absence of alerts to indicate if people had not received their care as assessed and planned. In addition, we identified a medication error which had not been found through the provider's existing governance systems.
- Where the provider's governance systems had identified areas for improvement action had not always been promptly followed through to address these and to advocate on people's behalves with health professionals. This included in respect of people experiencing a steady decline in weight loss, or to promptly maintain fire doors and their surrounds, to reduce risks to people further.
- The provider had not put robust systems in place to ensure staff roles and responsibilities were consistently clear. On the first day of this inspection the member of staff designated to oversee people's hydration had not arrived for work. Senior staff had not reassigned this to another staff member. The provider could not therefore be sure people's hydration was fully promoted. In addition, staff had not consistently been supported to understand the care people required, as information discussed during handover did not always trigger new care planning arrangements, to guide staff on the care people required.

- Opportunities to take learning from feedback were not always promptly taken. This included in relation to the storage of accelerants and combustible materials. We drew this to the attention of the provider's

representative on the first day of the inspection. This had not been addressed by the second day of the inspection.
● A new manager had recently been appointed at the home. They told us they intended to apply to CQC to become the registered manager. Changes to the staff representing the provider were also planned.

The provider had failed to have effective governance systems in place to assess and monitor the quality of the service to identify shortfall and to ensure compliance with regulations. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded to some elements of these concerns during and after the inspection. We contacted Herefordshire and Worcestershire Fire and Rescue Services regarding fire management concerns. We also made two safeguarding referrals to Herefordshire County Council's safeguarding team because we were concerned governance arrangements had not fully identified and mitigated risks to people.

● The manager and provider understood their responsibility to notify the CQC and other agencies of any significant events.

● The service failed to display the most recent CQC inspection rating at the home.

This was a breach of Regulation 20A (Requirement as to display performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We will follow our processes to consider an appropriate response to this outside the inspection process.

● After the inspection the provider's representatives provided assurances the rating was now displayed.

Working in partnership with others
● The manager and staff team continued to work with external agencies to improve infection control practices at the home.
● Further development was required to ensure people consistently benefited from living in a home where staff promptly sought and followed up referrals they made to people's GPs and to inform continual development of the care provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had sought the views of people's relatives on the quality of the care provided through a survey undertaken in 2021. Relatives highlighted they appreciated the support their family members had been given to keep in touch with them during the pandemic, when visiting was not possible. A suggestion had been made by people's relatives for improving relative's experience when they visited the home. There was no record this had been actioned. The provider's representative gave us assurances this would be addressed.
● Staff told us they felt the staff teams worked well together, but that changes in the management team and short notice changes to staffing had proved challenging. Staff said this situation had started to improve. One staff member told us they found the new manager was, "Very visible, very approachable and very supportive."
●We found staff concerns or suggestions were not always promptly responded to. For example, staff were

not able to access information on people's clinical needs in some areas of the building, owing to poor internet signal. This could place people at risk in emergency situations. Staff told us they had raised concerns with the provider's representatives about this. The providers representative told us this concern had been alerted to them in March 2021. The provider's representative gave us assurances this would be addressed.

● The manager told us they intended to focus on ensuring people's care plans reflected their needs and histories, making sure people had enough hydration and the recruitment of staff to provide meaningful activities for people to enjoy and additional clinical staff.

● We saw staff continued to offer everyday choices to people, so they could decide where they wanted to spend their time. Further development of the culture of the service by the provider was required, in order to ensure people consistently received care which fully considered their rights, choices and preferences. For example, by showing people plated alternative food options at the time they sat down to eat. Further, by centralising information regarding people's 'Do not attempt to resuscitate" forms and ensuring staff had been made aware of any DoLS conditions, so staff had immediate access to these.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibilities to be open and honest with people when something goes wrong.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not consistently been mitigated.

The enforcement action we took:

Imposed conditions on registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems had not driven through improvements in the premises and the management of people's risks.

The enforcement action we took:

Imposed conditions on registration.