Broadoak Group of Care Homes

Broadoak Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7 December 2015 and was unannounced.

Broadoak Grange is a care home for older people and is registered to accommodate up to 33 people requiring care because of old age, physical disability or dementia. At the time of our visit there were 31 people using the service.

There should be a registered manager at the service. 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. The manager had submitted her application to become the registered manager of the service and it was being processed at the time of our inspection.

People felt safe at the service. People felt able to talk to staff with any concerns. People received their medicines as prescribed. There was not appropriate information available relating to a person's covert medicine. People's privacy and dignity was respected.

There were sufficient staff on duty. Staff received training to enable them to meet people's needs. Staff had a good understanding of how to the various types of abuse and knew how to report issues internally and externally.

Risks relating to people's care had been assessed. Where a risk had been identified action had been taken to reduce the associated risk. Risks relating to the environment had not always been identified and assessed.

Where a change to people's health had been identified referrals to health professionals had been made. There was a risk that a person was not receiving the right professional support for their behaviours.

The service was working within the principles of the Mental Capacity Act 2005 (MCA). Where there was a reasonable doubt that a person lacked capacity to make decisions the service had a mental capacity care plan in place. However, the information relating to the people's mental capacity was not decision specific and therefore did not fully meet the requirements of the MCA legislation. The service had taken appropriate steps where they had identified that people were being deprived of their liberty in any way and they had made referrals to the local authority as is required.

People told us that the staff were kind and caring. Staff interactions with people were task focused and there were only limited times when staff engaged in general conversation with people.

People's needs were assessed and care plans had been put in place. Care plans contained limited information about people's likes, dislikes and preferences. People did not always receive personalised care

that was responsive to their needs.

Staff and the manager shared a vision of the service. Staff were clear about the expectations upon them within their roles. Staff felt valued and listened to and explained how they all worked together as a team.

Monitoring systems that were in place were not always effective at assessing, monitoring and improving the service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People felt safe at the service. Staff had a good understanding of the various types of abuse. Risks relating to people's care had been assessed. Risks relating to the environment had not always been identified and assessed. People received their medicines as prescribed. There was not appropriate information available relating to a person's covert medicine.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training to enable them to meet people's needs. Information relating to the people's mental capacity was not decision specific and therefore did not fully meet the requirements of the MCA legislation. Where a change to people's health had been identified referrals to health professionals had been made. People received plenty to eat and drink.

Is the service caring?

Good

The service was caring.

Staff were polite and kind to people. Staff did not always know about people's individual preferences and needs. Staff interactions with people were task focused and there were only limited times when staff engaged in general conversation with people. People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed and care plans had been put in place. Care plans contained limited information about people's likes, dislikes and preferences. People did not always receive personalised care that was responsive to their needs. People felt able to discuss any concerns with staff.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People spoke positively about the manager. Staff and the manager shared a vision of the service. Staff were clear about the expectations upon them within their roles. Systems that were in place were not always effective at assessing, monitoring and improving the service provision.

Broadoak Grange

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 7 December 2015 and was unannounced.

The inspection was carried out by two 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. The expert had experience of caring for family members who used dementia care services.

We reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted the local authority who had the responsibility to investigate safeguarding concerns at the service and funded some peoples care. We spoke with two district nurses' and two physiotherapists who visited the service on the day of our inspection.

We spoke with ten people who used the service and five relatives. The majority of people who used the service were elderly and had limited mobility and dementia. We observed the care they received and the interactions of staff. We spoke with the manager of the service, the assistant manager, four carers, the activities coordinator and the cook.

We examined in detail at the care of three people and we looked at the care records of four people relating to their specific needs. We looked at the incident and accident forms that had been completed for the past three months. We looked at documentation about how the service was managed. This included policies and procedures, four staff records and records associated with quality assurance processes. We also observed the care and support that people received.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at the service. One person told us, "Since I've been here, I've been well looked after. I feel safe everywhere." Another person told us, "I feel safe here." A relative told us, "I think [my relative's] safe. They look after them [people that use the service] well." Another relative told us, "It puts my mind at rest. [My relative] sleeps pretty well and knows [they] can ring the bell." However one person did tell us that people sometimes walked into their room. When this happened they told us, "I press my bell and staff sort them out." They went on to tell us that they thought this happened because of where their room was situated. Other people at the service told us that they did not experience this.

Staff had a good understanding of how to identify the various types of abuse and knew how to report issues internally and externally. They were also aware of the whistleblowing policy and how they were able to escalate any concerns both internally and externally. There was a safeguarding policy in place that included information about types of abuse that may occur and provided staff with guidance of what they should do if they identified or any possible abuse or anybody made any allegations of abuse. However, it did not include any contact details of any external agencies such as the local safeguarding authority where staff would need to report any concerns too. Staff confirmed that they would be able to find these from other sources such as the internet.

Risks relating to people's care had been assessed. We saw that where a risk had been identified action had been taken to reduce the associated risk. For example where person was at high risk of developing pressure sores positional changes were carried out while they were in bed. This would help to relief the pressure on certain points of their skin.

We saw that a number of environmental checks were carried out to ensure that service was safe. These included weekly checks on the temperature of the water and checks to ensure the safety of windows. However there were a number of environmental risks around the service that had not been assessed. For example the stairwells within the building were accessible to people and not always effectively protected and a room that was used for storage with spare equipment in it was left open for people to access. The manager confirmed that these issues had not been risk assessed. We also found that people were unable to have call bells and sensor mats connected in their rooms at the same time. This meant that when a person had a sensor mat plugged in they would be unable to use their call bell to summon staff assistance. This was discussed with the provider and rectified during the inspection.

We saw that accidents and incidents were recorded and contained details about how the accident or incident had occurred along with any follow up actions that had been undertaken. The manager reviewed all of the incident and accident forms and completed a monthly audit of incidents and accidents to enable them to identify any themes or trends.

People had emergency evacuation plans in place. These provided details about the amount of support people would need if an emergency situation arose and they needed to evacuate the building.

We received mixed responses from people about how long it took staff to respond if they needed them. One person told us, "Usually about 5 minutes but they're really good once they come." Another person told us, "Oh, they're good. There's no wait." However some people told us that they had to wait longer for staff to respond. One person told us, "Sometimes it takes a b***** long time. I don't time them though." Another person told us, "If my legs have been playing up and I need the loo at night, they come after about 5-10 minutes."

Staff told us on the whole that staffing levels were sufficient to meet people's needs. One staff member told us, "We sometimes work one down if people are sick and we can't cover. People sometimes have to wait a bit longer, it depends which staff are on and how quickly they work. We're one down maybe once or twice a week. We have very good staff." Another staff member told us, "If there's four on shift that's fine. If there's only three we struggle. We can't get to all the people at the same time. We always respond to buzzers because you don't know what's happened, but we do ask them [people that use the service] to wait for a minute. We work with three maybe once a week."

A visiting health professional in relation to the staffing levels told us, "Staff, it's better here than other places, it's not awful, but there's not quite enough." During our inspection we observed that staff responded to people's needs without delay and for the majority of the time a member of staff was available in the communal lounge.

We spoke with the manager about the staffing levels at the service. They told us about the staffing levels that they had in place. They told us that there were times when people were not able to come into work so they worked with less staff on the shift. They told us staff members who had worked on the previous shift would sometimes stay on to help out when this happened. They felt that people's needs were still met with three care staff and a senior on the shift. Staff that we spoke with confirmed this. We found that staffing levels at the time of our inspection were sufficient to meet people's needs.

The provider had a recruitment and selection procedure in place to ensure that appropriate checks were carried out on staff before they started work. We looked at the staff records for four people who currently worked at the service. We found that staff had completed an application form, had two references, an Independent Safeguarding Authority (ISA) first check and a Disclosure and Barring Service (DBS) check carried out. However we found that one staff member had started work one month prior to their DBS check being completed. This was a concern as the provider could not assure themselves that this person was of good character before they started work.

People told us that they received their medicines as and when they needed them, although people could not recall staff explaining to them what their tablets were for when they gave them to them. One person told us, "They don't explain them but I've had them so long." Another person told us, "I'm on so many pills. They're very good at issuing them." A third person told us, "I get them [my tablets] twice a day. I don't know what it's for."

We saw people's medicines were stored appropriately and people received their medicines as prescribed. However prescribed creams had not always been dated on opening and the receipt of medicines was not always consistently recorded on Medication Administration Record (MAR) charts. We were also concerned that a person was being given their medicines covertly with no authorisation letter from the GP. We saw that the GP's agreement to this had been recorded by a staff member in the details of their visit but the GP had not provided written consent to this. There were no details about how or why this decision had been made. There were no details of how this should be provided to the person. We looked at the provider's policy on covert medicines and we found that it stated that administering covert medication was an act of gross

misconduct and staff may be dismissed if they administered medication covertly. We discussed this with the manager who tried to contact the GP during our inspection but they were unavailable. The manager assured us that this matter was to be followed up as a priority.

We recommend that the service updates their medication policy to provide more detail and reflect national guidance in relation to the administration of covert medicines.

Requires Improvement

Is the service effective?

Our findings

People thought that staff had the appropriate skills and knowledge to meet their needs. One person told us, "The staff are good – they know what they're doing." Another person told us, "We're well looked after. The slightest thing and they sort it."

Staff told us that they had received training to enable them to fulfil their roles. They told us that their training was useful. One staff member told us, "The dignity training was particularly useful, it teaches you a lot more about how to speak to people." Staff members also confirmed that they received an induction when they first started at the service which included shadowing opportunities. We spoke with the manager about staff induction and training. They told us that they had six staff members currently undertaking level 2 and level 3 Health and Social Care Awards under the Qualifications and Credit Framework (QCF) and that they were looking to implement the Care Certificate for new staff members. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff told us that they received regular supervision and an annual appraisal. Records we saw confirmed this.

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. The application procedures for this in care homes and hospitals are 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 were being met. We found that the service had considered people's capacity within their care plans but where there was a reasonable doubt that people lacked the capacity to consent to their care and treatment decision specific MCA assessments had not been carried out. Staff were providing care to people who lacked the capacity to consent and there was no evidence of any best interest decisions that had been made. The information relating to the people's mental capacity was not decision specific and therefore did not fully meet the requirements of the MCA legislation.

We found that where the service had identified that a person may be being deprived of their liberty they had followed the requirements of DoLS and submitted an application to supervisory body to do so. However we were concerned that two people's standard DoLS authorisations had expired and this had not been identified or addressed by staff. For one person the service had been providing their care in exactly the same way for just over a three month period since their DoLS authorisation had expired. For another person their DoLS authorisation had expired one month prior to our inspection and this had not been identified or followed up in any way. We discussed this with the manager who told us they would ensure that this was followed up and a new referral made.

Although staff had received training in MCA they did not have a good understanding of how this affected their day to day work with people at the service. When we talked to staff about the MCA they confused capacity assessments with risk assessments and could not provide any examples of when best interest decisions may need to be made. Staff were not able to tell us who had a DoLS authorisation in place. We discussed our concerns with the manager who had a good understanding of MCA and DoLS and told us they were going to address the issues we had identified.

People told us that they received plenty to eat and drink and that the standard of the food was satisfactory. One person told us, "Its better some days than others. It's not lavish but its ok," another person told us, "It's simple food but it's OK. It's more than I can eat and I hate waste." Another person told us, "It's not as good as I'd like it to be. It's not always hot and they give you too much and it gets wasted. Soup out of a packet makes me mad. But breakfast is ok and you can have cooked if you want." A relative told us, "It's adequate, a good variety." Another relative told us, "She doesn't eat a lot now but always has the pudding. It looks lovely from what I've seen."

We saw that drinks and snacks were available throughout the day. The food menus in place were on a four week rolling cycle. We saw that there was a choice of two main meals for people at lunchtime. Staff members told us that people made their meal choices for that day during the morning. However, people were provided with their main meals with no explanation or reminder of what it was. People were not provided with a choice of desserts and there were no opportunities for people to help themselves to items such as additional gravy or juice. Food was all served pre-plated to people. We saw that people that required assistance with eating were provided with it and where people had opted not to have either of the menu options an alternative meal had been provided.

The cook told us that when people had specialist dietary needs or allergies to any foods then the manager informed them and they ensured that suitable options were available for them. However, at the time of our inspection nobody required any specialist diets. People were not rushed during their meals however there were missed opportunities for people to help themselves to items and provide them with more choice and control about what they had to eat and drink.

People told us that they were supported to access healthcare services when they needed them. One person told us, "The chiropodist comes here regularly and does my feet and the optician was a very good service." A relative told us, "[My relative's] legs were swelling up and they called the doctor and let my sister know. If they have a fall, they always ring and tell us. [My relative's] had a few falls here but at home it was 2-3 a day. I was here when the optician came and they treated [my relative] well." Another relative told us, "The home rang to get [my relative] seen by the doctor. They told me in the morning they were concerned, so got on with it." A visiting health professional told us, "I would be happy for my Mum to come here for the staff, I would. They pick up anything and action it. They are horrified if I question something and they think they have got it wrong."

We saw that where a change to people's health had been identified referrals to health professionals had been made. However we also saw that where a person displayed behaviours that challenged other health professionals had not been informed. One incident had lasted for over an hour. The incidents had been recorded but no consideration had been given to referring them to the GP or other health professionals. This meant that there was a risk that the person was not receiving the right professional support for their behaviours.

Good

Is the service caring?

Our findings

People told us that generally the staff were caring towards them. One person told us, "They have their off days but are very good. They're very much respectful." Another person told us, "They're very good." Another person told us, "The staff are excellent, they care and they talk to you like a human being." A relative told us, "They're very good and patient. It's a good atmosphere." Another relative told us, "They're very caring and I've seen them be good with the others [other people that used the service] too."

A visiting health professional told us, "Sometimes the staff don't know I'm here and they are always pleasant and kind." They went on to tell us, "The staff and manager seem to know the residents really well and can answer my questions." Another visiting health professional told us, "Some of the staff are very caring, go above and beyond but there are some that don't seem to have the time. Often we'll get 'well we don't know because we haven't been here' in response. There are some caring staff but we don't always see the same faces."

We saw throughout our inspection that staff were polite and kind in their interactions with people. However interactions were task focused and there were only limited times when staff engaged in general conversation with people. We saw that when people were distressed staff comforted them. One person told us, "If you're feeling down they [the staff] will put their arm around you." However we saw one person requested to go to bed as they were feeling unwell. They had to wait for 15 minutes as they needed two staff to assist them. During this time they appeared to be in discomfort in a communal area. The manager was aware of the situation but during this time staff was busy elsewhere.

Staff had an understanding of how to meet people's general needs although they did not always know about people's likes, dislikes, preferences and individual needs. Staff told us that people were easy to please, one staff member told us, "They [people at the service] are all easy happy people." Another staff member told us, "Not many [people at the service] are particular, one or two [people at the service] like to come down to the dining room at a certain time."

People told us that staff respected their privacy and dignity. They also told us that staff took actions such as closing the curtains and their bedroom door if they were assisting them with care. Staff members had a good understanding of how they were able to respect people's privacy and dignity while assisting them with care and told us about the actions they took. These included ensuring that people's curtains and door were closed. We also saw that signs were on people's bedroom doors that indicated either 'Do not Enter' or 'Welcome, please knock and come in'. People and staff members were able to turn these signs to show whether or not it was alright for people to go into their bedroom.

People told us that staff supported them to be as independent as they wanted to be. Staff members gave us examples of how they encouraged people to be as independent as they could be. One staff member told us how they supported people to wash as much of themselves as they were able to and encouraged people to use the toilet independently if they were able to. Another person told us how when they were assisting people with personal care they always gave people the flannel first and encouraged them to do as much for

themselves as possible. They then helped them out if needed.

People told us that friends and family could visit at any time. We looked at the signing in book which showed that people visited at various times. There were no undue restrictions on visiting hours.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback from people about their contributions towards their care plans. Some people did not believe that they had contributed towards them and other people told us that they had. A relative of a person that used the service told us how they had discussed their needs with the manager of the service. They told us that the staff provided care to meet their needs.

We saw that people's needs were assessed and that care plans had been put in place to meet their personal care needs. Care plans contained limited information about people's likes, dislikes and preferences. Things that were important to people such as religion and culture were not always considered within their care plans. For example for one person kept something with them as part of their religious beliefs. This was not recorded in their care plan and during our inspection we found that it had been left in their bedroom. This meant that people did not always receive personalised care that was responsive to their needs.

People told us that some activities took place. When asked specifically about activities, one person told us, "I like my telly. I don't join in anything but the chap who came to do the singsong yesterday was good." Another person told us, "It's only now and then. I just listen to talking books in my room." A third person told us, "We don't do much. There's nothing to do, just the odd bingo game." In relation to activities at the service a relative told us, "They do it in the big room. A bit of music or TV, sometimes colouring or knitting." Another relative told us, "[The activities staff member] does some things but they need more." The activities coordinator told us, "The residents don't like to do too much all at once. I tend to do an hour in the morning and alternate between the lounges."

During our inspection we saw that people were provided the opportunity to do some colouring during the afternoon, although people were not provided with anything to lean on. We also saw that the activities coordinator spent some time with people singing Christmas carols. There was an activities plan that showed that there was one activity available each day apart from on Sundays. Activities included bingo, skittles, pop the balloons and word searches. Activities took place in communal areas and were group based sessions. People who spent the majority of time in their rooms did not receive support to follow their hobbies and interests.

People told us that they would be able to talk to the staff if they wanted to make a complaint. One person told us, "I'd tell [the manager] she's very good for doing things." Another person told us, "It would help if they had name badges as I can't recall her name who I'd talk to." A relative told us, "If I had a complaint, I'd see [the manager] as she's approachable." Another relative told us, "I'd see [the manager or deputy manager] they're very easy to talk to."

The service had not received any complaints within the last 12 months but they had a complaints policy in place which provided details about how people could make a complaint. We saw that the complaints policy was displayed within a communal area of the service and it provided details about where people could refer their complaints to if they were not satisfied with the outcome from the service. However the policy did not include contact details for the local government ombudsman where people can refer their complaints to if

they not satisfied with the outcome from the service and it contained contact details for the Commission for Social Care Inspection which ceased to exist in 2009. Therefore the policy needed to be updated.

Requires Improvement

Is the service well-led?

Our findings

People spoke positively about the management of the service and told us that they sometimes got asked for their opinions about things. People told us that they could discuss anything with the registered manager or staff at the service. People and their relatives told us that they would recommend the service. Staff told us that the registered manager had an open door policy and they were able to discuss anything with them or the deputy manager in their absence. A relative told us, "Overall it's very good. You can talk to [the manager or deputy manager] about anything and things get done."

The manager at the service had applied to become the registered manager of the service and was going through the process at the time of our inspection. The manager at the service was aware of the requirements and responsibilities of their role. We had received some notifications from the service as required, although where people had DoLS authorisations in place these had not been reported to the Care Quality Commission as required. The manager was going revisit the CQC guidance to ensure that we were notified as required about all events at the service.

Staff and the manager shared a vision of the service. Staff were clear about the expectations upon them within their roles. Staff felt valued and listened to and explained how they all worked together as a team. Staff confirmed that handovers took place, they told us they found them useful and they received enough information about changes to people's needs. Staff told us that they felt assured that the manager would take action if there were any concerns. One staff member told us, "They [the manager] would take action if care standards dropped, they'd talk to us as a team."

A visiting health professional told us, "The manager is excellent and knows the residents. They expect to have handover when I've finished. Since this manager took over it's got a very good reputation with the district nurses. They [the staff] actually care about the residents. I've no concerns with this home and it did use to be a big problem for us."

The provider had procedures for monitoring and assessing the quality of the service. This included seeking relative's views of the service through an annual survey. A survey was completed in July 2015. Relative's responses about the service were positive. Comments received included, 'Thank you for doing a very difficult job,' and 'Staff are friendly and caring, I think they do a wonderful job.' We saw that areas for improvement suggested by relatives included the request for a stronger broadband signal so relatives were able to Skype, the request for a ramp at the front door to make it more easily accessible and the request for more stimulation. The provider told us that the broadband signal had been upgraded and people were now able to Skype relatives although this was still not available in people's individual rooms. The activities were work in progress and a ramp had been made for the front door but people and staff found this heavy to move and put in place. We discussed this with the manager and provider who advised us that they would look into alternative options for access at the front door.

However monitoring systems that were in place had failed to identify that people's DoLS authorisations had expired and had failed to identify that people's individual preferences were not always being met. Systems

had also failed to identify that there were a number of environmental risks around the service that had not been assessed. This meant that systems that were in place were not always effectively assessing, monitoring and improving the service provision.