Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Broadacres

Hall Road, Barton Turf, Norwich, NR12 8AR

Tel: 01692630939

Date of Inspection: 13 September 2014

Date of Publication: October 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Mr & Mrs M J Muir-Smith
Overview of the service	Broadacres is a residential home for up to 28 older people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 13 September 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

What people told us and what we found

At the time of our inspection there were 16 people using the service. One adult social care inspector carried out the visit.

We spoke with the assistant manager, three care staff and five people who used the service. The service did not have a CQC registered manager in place. The assistant manager told us that the provider was in the process of appointing someone.

We reviewed the care records for four people. We also reviewed a selection of other records. These included staffing rotas, minutes from meetings and audit results.

We used the evidence we collected during our inspection to answer five questions.

Is the service safe?

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA), 2005, and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA provides a framework to empower and protect people who may make key decisions about their care and support. The DoLS are used if extra restrictions or restraints are needed which may deprive a person of their liberty. We saw evidence that the provider had acted in accordance with the law in relation to the MCA and DoLS. People who used the service had received appropriate mental capacity assessments and a number of 'best interest' decisions were recorded. At the time of this inspection no person living in Broadacres had a DoLS authorisation.

Risk assessments had been completed for people and were reviewed on a monthly basis. The purpose of these was to minimise the risks to people in relation to their needs.

There were effective systems in place to reduce the risk and spread of infection. The provider had an infection control policy and we saw that this was followed by the different staff groups. Hygiene and cleanliness were monitored on a daily basis.

People who used the service told us that they felt there were enough staff on duty to meet their needs at all times. We reviewed four weeks of staff rotas and noted that the numbers of staff on duty reflected the provider's staffing requirements.

There were effective systems in place to record and investigate accidents and incidents. We saw that the provider took actions to help reduce the likelihood of repeat occurrences.

The provider had effective arrangements in place to manage foreseeable emergencies. These included plans in relation to fire and the loss of utilities.

Is the service effective?

People's needs were assessed, and care and support was planned and delivered in order to meet these needs. Nationally recognised tools were used in the assessment of people's needs. These included the 'Malnutrition Universal Screening Tool' (MUST) for people at risk of malnutrition or obesity, and the 'Waterlow Pressure Area Tool' that helped to determine whether people were at risk of developing pressure sores.

We saw evidence that people's needs were being met. The care and support delivered by staff reflected what had been documented in people's care plans. People's records were up to date and included any changes in their needs.

During the review of four people's care plans we saw evidence that the provider worked closely with other health and social care professionals. These included physiotherapists, dieticians and district nurses. This meant that people received care from a multidisciplinary team that helped to address all of their needs.

Is the service caring?

We spoke with five people who used the service and received positive comments from each person. One person said, "I am happy here and the food is excellent. The staff are lovely." Another person said, "I get well looked after. I choose to stay in my room most of the time but there are things to join in with if you like. The staff are excellent; very kind. I have no complaints or concerns." A third person said, "I like to go down to the (service's) pond and sit there. It's lovely living here. I have no complaints."

During our inspection we found that people were supported by compassionate and attentive staff. People told us that they chose when they wanted staff to assist and support them. An example of this was people choosing whether they had a bath or shower in the morning or the evening.

It was evident that the staff knew the needs of people well. People's privacy and dignity were maintained at all times during our inspection.

Is the service responsive?

People's care plans responded to and reflected their physical, emotional and social needs. People's likes, dislikes and preferences were recorded. The care and support that people received met their preferences. People could choose how they wished to spend the day and the staff respected their decisions. People had access to activities that they enjoyed. The people who we spoke with told us that their relatives and friends were always welcomed at Broadacres.

We saw evidence that learning from complaints and concerns took place. Complaints were audited on a monthly basis and the provider took account of them to help improve the quality of the service.

Is the service well-led?

The service did not have a CQC registered manager in place. The assistant manager told us that the provider was in the process of appointing someone. They told us that the provider had written to the people who used the service to explain why there wasn't a registered manager in post.

The assistant manager told us that they managed the day to day running of the service. They said that they were supported by a care manager and administration team. All of the care staff we spoke with told us that they felt well supported. An agency care worker, who worked regular shifts at the service said, "I love working in this home. I have been really welcomed and feel part of the team. Everyone works well together and the assistant manager is fantastic."

The staff we spoke with could tell us about the quality assurance processes that were in place. These included regular audits of all aspects of the service. Satisfaction surveys had been conducted and the provider had sought the views from different groups of people. These included people's relatives and other health and social care professionals who visited the service. Action plans had been formulated and implemented for any areas of the service that required improvement.

The staff we spoke with understood their roles and responsibilities. There was a senior care worker on each shift and staff told us that they would escalate any concerns that they had to this person. There was an on-call system for staff to contact a senior person or manager out of hours.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We reviewed four people's care records and found that before people received any care or support they were asked for their consent and the provider acted in accordance with their wishes. People, where possible, had signed their care plans and risk assessments to state that they had agreed with what had been documented. For people who were unable to sign their care records, an explanation as to why was documented. People had given their consent for the sharing of their information with other health and social care professionals and their relatives.

Where people did not have the mental capacity to consent to their care and support, the provider had systems in place to ensure that they acted in accordance with legal requirements. We saw that people had mental capacity assessments that followed the principles of the Mental Capacity Act (MCA), 2005. A number of people had 'best decisions' records. An example of this was for one person to always be transferred with the use of a hoist. Another example was to keep a person's patio door locked to help ensure their safety and welfare. We noted that there was documentation about people's 'Lasting Power of Attorney' (LPA) in their care records. The information related to 'best decisions' records and the LPA's involvement in relation to these.

Three of the care plans that we reviewed contained people's 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions. There was documentation to show that the person concerned had been involved in the decision and had signed to state their agreement. One person had been assessed as lacking mental capacity in relation to this decision. We saw that the person's LPA had given their consent for the DNACPR decision. The decision had been made in line with the MCA, 2005. We noted that each person with a DNACPR decision in place had an end of life care plan. This documented people's wishes for their end of life care. People and their relatives where appropriate, had been

involved in making the advanced care decisions and had signed their plan to state their agreement.

People who used the service were only deprived of their liberty when this had been authorised by the Court of Protection, or by a Supervisory Body under the Deprivation of Liberty Safeguards. At the time of this inspection no person had this authorisation in place.

We spoke with three care staff and each person displayed a good understanding about mental capacity and consent.

During our inspection we observed staff to seek the consent from people before delivering any care or support. An example of this was staff knocking on people's doors and waiting to be invited in before entering.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with five people who used the service and received positive comments from each person. One person said, "I am happy here and the food is excellent. The staff are lovely." Another person said, "I get well looked after. I choose to stay in my room most of the time but there are things to join in with if you like. The staff are excellent; very kind. I have no complaints or concerns." A third person said, "I like to go down to the (service's) pond and sit there. It's lovely living here. I have no complaints."

We reviewed four people's care records and found people's needs were assessed and care and support was planned and delivered in line with their individual care plan. People's care plans were detailed and tailored to their individual needs. All aspects of people's activities of daily living had been assessed. These included their hygiene, mobility and nutritional needs. There was detailed information in relation to people's emotional and social needs. This included people's likes, dislikes and preferences. We noted that other health professionals had been consulted in the on-going assessment of people's needs. This included a physiotherapist who visited the service on a weekly basis. We noted that people received an assessment from the physiotherapist on arrival to Broadacres, as well as on an on-going basis if required. The physiotherapist had given instructions to staff to help them meet the needs of people in relation to their mobility and their safe moving and handling. A dietician had been consulted in relation to people's nutritional needs. People's care plans included information from the dietician that informed staff of how to meet their needs. This included people being on a fortified diet with high protein and calories intake to help ensure they were not at risk of malnutrition.

Care and support was planned and delivered in a way that was intended to ensure people's safety and welfare. Each person had risk assessments in place that related to their individual needs. These included risks in relation to drinking alcohol and taking medication, the use of the lift unaccompanied and potential physical aggression. We noted that nationally recognised screening tools had been effectively used. These included the 'Malnutrition Universal Screening Tool' (MUST). This is a five-step screening tool to identify adults who were malnourished, at risk of malnutrition or obese. Another screening tool that was used was the 'Waterlow Pressure Area Tool.' This helped to determine whether people were at risk of developing pressure sores. Each person's risk assessments

had been reviewed on a monthly basis.

Throughout our inspection we saw evidence that people's needs had been met. The care staff showed a good understanding of each person's needs and could tell us about the care and support people required. The care that people received reflected what had been documented in their records.

We saw evidence that people's social and emotional needs were being met. There was an activities schedule on the 'residents'' notice board as well as in people's individual rooms. The activities included indoor bowls, quizzes and gentle exercises. The people we spoke with told us that they were encouraged to join in with the activities. They said that if they chose to stay in their rooms then this was respected by the staff. The service had different communal areas for people to choose to spend time in. These included a television room, a library and an activities area. The service had extensive gardens and a pond. People told us that they enjoyed spending time in the gardens and that they found sitting next to the pond 'very peaceful.'

There were arrangements in place to deal with foreseeable emergencies. The assistant manager showed us the provider's emergency policy. This included plans in the event of a fire, flooding, management emergency and the loss of water and utilities. The plans were accessible to the staff.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

During our inspection we found that there were effective systems in place to reduce the risk and spread of infection. We looked at all of the communal areas, the laundry, the kitchen and food cellar and a number of people's individual rooms. All areas were visibly clean. The people we spoke with who commented on the cleanliness of the service told us that it was always clean.

The provider had an infection control policy and this was in date. We saw evidence that staff followed the information contained within the policy. Linen was correctly segregated in the laundry area. We saw that contaminated linen was washed in red water soluble bags. This helped to ensure that laundry was correctly handled and minimised the risk of infection.

We saw that Personal Protective Equipment (PPE) was readily available for staff in the relevant areas. PPE included disposable gloves and aprons. We noted that staff handling or serving food wore blue aprons. There were adequate hand washing and hand drying facilities throughout the home. We found that hand sanitizer gel dispensers were available throughout the service, including the front door for visitors to use.

The kitchen areas were clean and hygienic. Colour coded food and chopping boards were used to help reduce the contamination of food from other foods. We reviewed the quality assurance daily checks for these areas. The checks included the cleaning and deep cleaning of the areas, the storage of food and the temperature of the fridges and freezers. We found that the records clearly demonstrated that the procedures followed in the kitchen reduced the risk and spread of infection.

Waste was correctly disposed of. This included putting waste items into different coloured bags and disposing of them appropriately and securely.

The provider had a policy in relation to the Control of Substance Hazardous to Health (COSHH) regulations, 2002. There was information available to staff in areas such as the

laundry and kitchen in relation to these regulations. We found that substances such as cleaning products were securely stored. The staff we spoke with showed a good understanding about COSHH.

We spoke with a senior care worker who told us that they were the lead person for infection control. They told us that they were qualified to teach other staff about infection prevention and control. The other care staff we spoke with could tell us about the different types of infections people could have and how these should be managed. They explained the importance of following the provider's infection control policy and told us that there were always adequate supplies of PPE.

The assistant manager showed us how the service was audited in relation to infection prevention and control. We saw that regular cleaning audits took place. We noted that any actions arising from the audits had been addressed. Besides the cleanliness and hygiene of the kitchen area being monitored on a daily and weekly basis, we saw that an external audit had taken place in July 2014. There was evidence that the provider had taken the necessary steps to address the actions arising from the audit. There were systems in place at the service to control and prevent the risk of infection.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

The people we spoke with who used the service told us that they felt there were enough staff on duty, at all times, to meet their needs. One person said, "I feel there are enough staff on duty. I never have to wait long for assistance. The staff help me with my personal care at a time that suits me. The staff take me out into the garden in a wheelchair whenever I ask them to."

All of the care staff we spoke with told us that they felt there were enough staff. They told us that people were supported in a timely manner, and at a time that suited the individual. They gave us an example of assisting people with having a shower or a bath either in the morning or the evening, dependent on the person's choice.

The provider's required numbers of care staff were four in the morning, three in the afternoon and two during the night. The assistant manager told us that there was always a senior care worker on duty. We reviewed the staff rotas for a four week period, including the week of our inspection. We saw evidence that the provider's required number of care staff and seniority of care staff was met all of the time.

The assistant manager told us that any shortfalls in the staffing numbers were covered by the service's permanent staff or by a regular agency care worker. We saw this this was the case. The service had an on-call system. This meant that care staff could contact a senior person or manager during the out of hour's period.

Throughout our inspection we observed staff attending to people in a timely manner. People's call bells were answered within five minutes. Staff took their time when they delivered care and support and did not rush people. We saw that staff were able to sit and speak with the people they cared for.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We asked the assistant manager how the quality of the service was assessed and monitored. They told us that people who used the service, their representatives and staff were asked for their views about their care and support and they were acted on. We saw evidence that this was the case. We reviewed the audit results from numerous surveys that collected the views from different people. These included surveys completed by people living in Broadacres, people's relatives and professionals such as people's general practitioners, district nurses and chiropodists. We saw that there were completed surveys in relation to different aspects of the home. These included collecting people's views about the library, menu choices and activities. The results from the surveys were effectively used. An example of this was the survey in relation to the library. The results informed the mobile library as to what type of books they should take to the service in order to meet people's preferences. We noted that there had been a recent staff survey. The results from this survey were positive in relation to all aspects of the service and people's working lives.

The assistant manager told us that there were 'residents' meetings every six months. We reviewed the minutes from the meeting held in March 2014 and found that people's views had been sought in relation to the quality of the service. Any ideas for improving the service or any complaints had been acted upon.

The assistant manager showed us the minutes from the staff meetings. The meetings were on a rolling programme for the different staff groups. We noted that staff were encouraged to raise any issues with the service and saw that these were acted upon where appropriate. The staff who we spoke with told us that the meetings were meaningful to them. One person said, "I go to the staff meetings. I feel that they are productive and that I am listened to."

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. The provider had an accidents and incidents

policy. All of the staff we spoke with could tell us what they would do if a person had an accident. We saw evidence that accidents and incidents were audited on a monthly basis. The provider undertook a root-cause analysis of any accidents and identified any person as being at risk of having further accidents. We saw that people identified at risk, had appropriate actions put in place to help reduce a repeat occurrence. The provider also audited accidents to help determine if they happened at any particular time of the day. The assistant manager told us that this was done to determine if there were any particular risks associated with different times of the day such as staffing numbers.

All of the staff we spoke with could tell us about the provider's complaint procedure and what they would do if a person wished to make a complaint. We saw evidence that complaints were audited on a monthly basis. The assistant manager told us that complaints were discussed at staff meetings and that lessons learnt from complaints were communicated to all staff members. This meant that the provider took account of complaints and comments to improve the service.

The provider had an audit programme in place. The programme covered all aspects of the service including people's care plans, medicines management and the maintenance of the home. The audit results were available to us. We noted that the provider acted upon anything that required improvement.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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