Cheltenham Care Ltd

Broadleas Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 15 and 16 January 2016 and was unannounced.

Broadleas provides care to predominantly older people. Some live with dementia and others have physical needs which they require support with. It can accommodate 20 people in total and at the time of the inspection 17 people lived there.

A registered manager was in place and they had managed the service since February 2015. They had however worked at Broadleas for eight years. 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.

People were kept safe, their risks were managed and monitored and there were enough staff to ensure people's needs were met. The staff were good at recognising people as individuals and tailoring care to suit people's individual needs. People and their representatives were involved in providing information which helped staff develop very personalised care plans. These gave staff good guidance on how people's needs were to be met. The code of practice for the Mental Capacity Act 2005 was adhered to and people were supported to make independent day to day choices and decisions. Where more significant decisions had been made and where the person had lacked mental capacity to do this the legislation had been adhered to. Decisions had therefore been made in the person's best interests by appropriate people. Some improvements were needed to how people's lack of capacity was reflected in their care planning and, in some cases, further advice was needed with regard to whether people's liberty had been deprived. Staff ensured people had access to health care professionals and when appropriate that their advice was followed.

Staff were caring and compassionate and the people they looked after mattered to them. They provided reassurance and support to people in moments of distress and patiently built relationships up with people who were confused. People had access to activities and were supported to go out in the local community. Visitors were welcomed at any time.

People were able to raise concerns and complaints because the registered manager was open and approachable. Staff were supported well and any areas of poor competency or practice were addressed. The registered manager was a strong leader and had clear expectations and values which the staff were aware of. She was recognised as a person who was totally committed to the care of those who lived at Broadleas. She said, "The residents come first". These values were promoted by senior staff and acted on by the staff who worked very much as a team. All staff were committed to providing people with good care and a good quality of life.

Good monitoring systems were in place to ensure the services provided remained safe, compliant and of a

good standard. The provider supported the service well and was committed to making improvements which benefitted those who lived at Broadleas.

We recommend that the service seek advice and guidance from a reputable source, about how best to reference consideration of the Mental Capacity Act when planning people's care.

We also recommend that the service seek advice and guidance as to whether further applications under DoLS are required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected against risks that may affect them. Environmental risks were also monitored, identified and managed.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Is the service effective?

Requires Improvement

The service was effective although it needed to ensure this was the case on an individual basis where the Mental Capacity Act was concerned. In practice the staff adhered to the principles of the Act and supported individual decision making. However, further advice was needed to ensure the service was fully and correctly implementing the legislation.

People received care and treatment from staff who had been trained well to do this. Where staff were new there were arrangements in place to help them learn and improve their skills.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff ensured people's health care needs were met by working effectively with external health care professionals.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who delivered care in a compassionate way. Staff adopted a personalised approach to care. They met people's needs as they arose and in a way which suited that person.

People's preferences were explored and met by the staff where possible.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Good

The service was responsive. People's needs were well assessed and planned for. Once people were admitted the assessment process continued and care plans evolved further.

Care plans were well maintained and personalised. They contained people's likes, dislikes and preferences.

People had opportunities to socialise and partake in activities and the staff were trying hard to make these activities more meaningful to people.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well-led. There were good arrangements in place to monitor services and practices and to make any necessary improvements.

The manager's expectations and values were understood by the staff who promoted these and acted on them. Staff were committed to providing people with a good standard of care.

The management team were open to people's suggestions and comments and acted on these in order to improve the service.

Broadleas Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 15 and 16 January 2016 and was unannounced. It was carried out by one inspector. This was the first inspection of the service under the current provider. Prior to the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the statutory notifications we held. This is when the provider tells us about significant events which have taken place. They include: notice of a person's death, a serious injury, any allegations of abuse or an event which prevents the smooth running of the service.

When we visited the service we spoke with three people who lived at Broadleas about the care and services they received. We met others who were not able to tell us about their experiences so 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 also spoke with five relatives and one other visitor. We reviewed the care files of six people which contained pre-admission information, care plans and risk assessments. We also reviewed a selection of other people's falls risk assessments and eight people's medicine administration records. We spoke with four staff, as well as the registered manager and a Director of the company. We reviewed three staff recruitment files which included their training certificates and support records.

We also reviewed additional records and documents which related to the management of the service. These included, the service's safeguarding policy and procedures, several audits, the provider's improvement plan, accident and incidents records, minutes of resident and relative meetings as well as staff meetings. We

reviewed the service's record of complaints, compliments and read questionnaires which had been sent to people by the provider to seek their view of the service. We also had a tour of the premises and observed a staff hand-over meeting.

Good

Is the service safe?

Our findings

Prior to the inspection we had been informed of a person's fall by a health care professional. This had taken place just a couple of days after the person's admission to the home. We therefore reviewed the service's accident audits to ascertain how many accidents took place, if any particular type of accident was more prevalent and if appropriate action had followed. We also wanted to explore if the audits were used to identify any trends and patterns and if these were identified, what action had been taken to reduce the risk of a reoccurrence. We also reviewed the care records of the person who had fallen as well as the registered manager's investigation records. These records showed that staff on duty had been aware of the person's risk of disorientation as the environment was new to them. They had taken action to try and orientate the person and engage them in conversation rather than walking around the home too much. The person's mobility assessment recorded the person as able to walk without an aid and able to manage stairs. Actions taken on finding the person on the floor after their fall had been appropriate and paramedics were called straight away.

The registered manager explained the staff did not restrict people in anyway. They told us that after the first week, the person's GP would be asked to review them as well as their medicines. The registered manager told us quite often people were admitted on multiple combinations of medicines and sedatives, that when in the care home, were often not needed as problems could be managed in other ways. The registered manager said the home were keen to reduce all sedative medicines where possible because this effected people's ability to generally function as well as stand and walk safely. They told us staff supported people to have a good quality of life whilst living with dementia and therefore, within people's abilities, independence was promoted. They acknowledged that with this approach came risks but all actions possible were taken to reduce these. The registered manager also told us they could not offer constant one to one supervision and control for every person who was assessed as a high risk of falling. Neither would this be appropriate or correct to do so.

We inspected monthly accident audits from Sept 2014 to December 2015. The numbers of accidents varied each month. Slips and falls were recorded as the most common accident. The registered manager told us the audit information was then examined by her to look for obvious trends and patterns. For example, looking at if accidents/falls were taking place at a particular time of day, when particular staff were on duty, accidents happening in the same location and if any one person was falling more frequently than others. The latter had been the case during one month and the person's GP had been involved early on. The staff had also involved mental health specialists because a decline in the person's mental health had altered their behaviour and the result had been the person had been found on the floor several times.

We saw from other recorded actions that medicine reviews had taken place following a fall. These had involved stopping particular medicines, adjusting doses or times of administration to see if this helped to avoid a reoccurrence. In some later follow ups on the effectiveness of this action this had proven to be successful with no more falls being recorded. After some falls an occupational therapist had been involved. Equipment such as walking aids and different types of beds had been introduced to help people stay safe. The use of electronic equipment such as alarmed pressure mats had also been used. These alerted staff to a

person's movement so they could arrive early and provide support before a potential fall occurred. In one person's case a fall usually indicated the start of an infection so early involvement of the GP had in the past resulted in a course of treatment and no more falls occurred.

Other actions in and outside of the home had been taken to reduce and prevent falls. For example, the new provider had taken advice from the registered manager and altered three steps in the main hall-way. The registered manager told us people had slipped or fallen on these previously. The depth and width of these were altered, the steps themselves and their edges had been made more obvious and the lighting adjusted above them. The registered manager confirmed this action had reduced the numbers of near misses/accidents on these steps. Other work was in progress outside of the building and improved lighting and footpaths had already been completed.

We could see that the service had been proactive in identifying potential risks. They had taken appropriate action when an accident had happened and then looked at how to prevent a reoccurrence. One of the options given on the service's risk assessment for high risk categories had been to request advice from the local falls team. This had not been done to date because the registered manager had considered each fall had been well followed up. We suggested that the falls team may be able to offer further advice or just confirm that the staff were doing all that was possible to prevent falls. The registered manager told us they would do this following the inspection.

At the end of one of the inspection days a person fell. We observed staff manage the situation well. This person had been assessed as a high risk for falls and as someone who wanted to remain as independent as possible. The relevant risk assessment and care plan were up to date and gave guidance to staff to ensure all actions were taken to prevent a fall. This included making sure for example, the person sat by a call bell but, it also acknowledged that the person did not like to use it, making sure they had well-fitting footwear on and for staff to be aware of the person's whereabouts as much as was practicable. The actions in the care plan had been followed as well as those to follow following a fall. We observed the person being safely supported to pick themselves up off the floor following a check for any injuries. One member of staff told us what they had done to check for injuries which had been in line with first aid training they had received.

Other assessed risks included, those related to the development of pressure ulcers, use of equipment, behaviour which could be perceived as challenging, nutrition and fire safety and evacuation. Appropriate risk assessment and care plans were in place explaining the hazard, the level of risk and what action staff must take to keep people safe. One person's risks relating to a particular health condition they had were identified. Likely triggers for a decline in health were recorded and further guidance told staff what to look out for and then what action to take. Risks to people were therefore identified and well managed and monitored.

The company Director discussed with us their role in making sure people were safe. Their role was to ensure monies were used appropriately so that safety issues were prioritised and addressed. This had included the alteration of the three steps in the hallway, making sure funds were available to upgrade the fire prevention, detection and alarm systems. Work was taking place in the kitchen to refurbish it and to ensure it met with the Food Standards Agency's requirements. Improvements were also planned for the laundry facilities. Further landscaping outside of the building would take place to ensure people could continue to use the outside space safely and comfortably. The Director had also released funds for specific alterations to be made to one person's bedroom so they could return to Broadleas following an illness and subsequent hospital care. This had involved reconfiguring their bedroom and bathroom facilities so more floor space could be achieved. This was done at the provider's expense so the person could return to their 'home', Broadleas. This enabled new and necessary equipment to be used safely.

The registered manager confirmed there were enough staff on duty to meet people's needs. One member of staff explained that when the above person had returned from hospital and they required two care staff to manoeuvre them, the company Director had agreed to an increase in care staff. The staffing was therefore increased by one member of staff in the morning and afternoon to accommodate these needs. This member of staff also said this had provided staff with more opportunities to spend time with other people in the afternoons.

In the afternoon between 2pm and 8pm there were three care staff on duty and a cook until 6pm each day. Staff numbers dropped to two at 8pm and, from 11pm until 6am there was one waking night staff. The registered manager told us the sleeping night staff was there if help was needed but was very rarely used. We discussed the deployment of staff after 8pm when people wanted help to go to bed and one member of staff was administering medicines. The registered manager told us the needs of the people could be met by one member of staff until the second member of staff was able to help with the care which took two staff to provide. The registered manager agreed that at times this would leave some people unsupervised in communal areas but staff would be checking on a regular basis in-between helping others to bed. When people's needs in the past had increased and they had required a higher level of supervision or support they had been reassessed for nursing care and moved to a nursing home.

People were protected from abuse because staff knew how to recognise signs of this and report any concerns they may have. They had received training on the subject and were aware they needed to be particularly aware that people at Broadleas could not always verbally tell them if something was wrong. One member of staff told us they needed to be aware of other signs which may indicate abuse such as unexplained bruises, pain or fear. The home had a safeguarding policy and staff were aware of this and its associated procedures. This had been reviewed in October 2014. They were also aware of the local county council's responsibilities in relation to safeguarding people from abuse and their policy and protocols were present. This included the safeguarding of any children who visited the home. Contact numbers for all relevant agencies involved in safeguarding people were available to staff. The subject of safeguarding people was discussed in staffs' supervision (support) sessions. A visitor to the home told us they would have no problem in reporting any concerns they had in respect of this. There was no information available for people or visitors on safeguarding adults and the registered manager said they would address this.

Appropriate staff recruitment processes helped to protect people from those who may not be suitable to care for them. All the recruitment files inspected showed that appropriate checks had been carried out before the staff started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and in particular, when past jobs had been with another care provider. Employment histories were requested and the reasons for any gaps explored at interview.

People received their medicines safely. We observed medicines being administered and inspected the medicines system generally and the arrangements for storage. The arrangements were in line with the principles of the Royal Pharmaceutical Society's guidance: Safe Handling of Medicines in Social Care. The staff who administered medicines had received appropriate training and their competencies in this task were reviewed on a regular basis. Although medicines were administered at lunch-time, people were asked first if they minded taking their medicines at that time. Medicines that required a more interactive involvement to administer such as creams, inhalers and eye drops were administered in private. One person had been administered a continual low dose of medicine as a preventative strategy against infection. This had been administered as prescribed and a relevant care plan was in place explaining why this had been prescribed.

People lived in a safe environment and relevant risk assessments were in place. At the time of the inspection the commercial washing machine was being mended and a domestic alternative had been installed. In order to ensure soiled linen could still be managed safely some changes to the process of managing this had been put in to place and were being followed. A risk assessment however, explaining what the risks were and the actions taken to reduce these had not been recorded. This was completed by the end of the inspection. Numerous health and safety checks/audits were carried out to ensure people remained safe. We saw records which recorded frequent monitoring and servicing of various systems and equipment. Risk assessments had been completed in relation to general health and safety risks. A fire risk assessment had been completed and a fire audit carried out by the local fire safety officer in 2014. Recommendations from these had been completed. One had been to have simpler information at hand in relation to what support each person needed in the event of needing to evacuate the building. Detailed personal emergency evacuation plans (PEEPs) had already been in place but the fire officer had suggested a "quick reference guide". This had been completed. Contracts were in place with various service providers and maintenance companies. For example, a specialist company serviced and maintained all lifting equipment, which included the passenger lift. Similar arrangements were in place to maintain the call bell system, emergency lighting, fire alarm system and fire safety equipment.

The home had an action plan in place for serious and unplanned emergencies.

Requires Improvement

Is the service effective?

Our findings

People at Broadleas were presumed to have mental capacity to make decisions about their care and treatment until something made the staff doubt the person's ability to do this. This was despite the fact that some people lived with dementia. The registered manager explained that people's mental capacity could fluctuate and people needed to be able to provide consent or make a decision, at the time it was needed. People's care records showed that staff therefore had sometimes needed to return to people, at different times, to provide their care when they were better able to make a decision about this a provide their consent. For example, a person who was known to be confused when they first woke up and refused care would be better approached later in the morning when they were more awake, less confused and more able to provide consent. The registered manager explained there were no mental capacity assessments in place because, up to this point, people had been able to make decisions and give consent, when it had been needed, because these sorts of arrangements were in place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff understood that they could not force care or treatment on people who were not providing consent. We saw people being supported to make decisions and choices about their care or treatment. Care plans recorded people's likes, dislikes and preferences and care was tailored to people's individual needs, which helped staff accomplish this. The registered manager explained that one person who had previously lived at Broadleas had started to refuse care and treatment. This had affected the person's well-being and health and health care professionals subsequently assessed the person as lacking mental capacity. In this case professionals made decisions about the person's care and treatment on their behalf and in their best interests. The principles of the MCA were being adhered to and people who lacked mental capacity were protected by this.

Lacking however, in people's care plans, was reference to the fact that people did however have a brain impairment, for example, dementia, that they were at risk of lacking mental capacity and how staff would continue to support their decision making. Care records did not record information about people's power of attorney arrangements and if anyone held this for health and welfare. Staff would need this information if best interests decisions were needed to be made to ensure the appropriate people were involved in the decision making process. In some circumstances this information would be needed to ensure the correct people were given information about people's health care.

The registered manager told us no one was deprived of their liberty and no referrals for authorisation under the Deprivation of Liberty Safeguards had been needed. 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). There was a key pad lock on the front door and we were told one person had the number to this and was able to leave the building alone. We were told that when others wished to go out staff took them out.

We were told that going out was a regular social activity for people when the weather was good. We however observed one person pulling on the front door. This was repeated several times during or visit and the door remained locked. On one occasion they were distracted from doing this by a member of staff offering their hand and suggesting, kindly, that they come and have a cup of tea. Although this person was not verbally expressing a wish to leave and they could be distracted they were not free to exit the care home. Staff told us they would not let this person leave unsupervised because they lived with dementia and it would not be safe to do this at the moment. In this case an application to the local supervisory body (the County Council) for DoLS was appropriate but had not been done. The registered manager explained that the person had not been in the home for long and she had not observed this behaviour before. We recommended that as we had observed the person pulling at the front door and repeating this action advice should be taken from the County Council's MCA/DoLS Helpdesk which the registered manager said they would do.

People and their representatives told us their needs were met well. One person had been admitted to Broadleas for an initial short period of time. Their relative said, "We looked at two other care homes and one felt very regimented, this one did not. We chose the right one". One person said, "I think it's a very good home". This person explained that the move to a care home had been a very difficult decision but they were glad they had made it. One visitor had witnessed a close relative's care in another care home and did not feel this had been very good. They said, "They (staff) are brilliant here, I would say exceptional really".

People's needs were met by staff who had received training which enabled them to do this well. All staff who started work at the home completed induction training. Records in staff training files showed this training had linked to modules within the Skills for Care Common Induction Standards (CIS). Staff had therefore received a nationally recognised standard of induction training. The registered manager was aware of the new Care Certificate. This would be used to provide new staff in the future with comprehensive induction training. The registered manager and deputy manager had already completed the mentor's course related to this. The certificate lays down a new framework of training and support which new care staff can receive. Its aim is that care staff will be able to deliver safe and effective care to a recognised standard once this is completed. Staff training generally was delivered in a way which best suited the individual staff member's learning needs and abilities.

The training record and staff training certificates showed staff had received training in subjects which the provider considered to be necessary for all staff. These subjects included fire safety, infection control, safeguarding adults and safe moving and handling. Some care staff had then completed additional training in subjects such as, end of life care, dementia care, catheter care, care of pressure ulcers, the Mental Capacity Act and Deprivation of Liberty Safeguards, diabetes training and delirium awareness. 11 staff (which includes the registered manager) out of 13 had completed or were in the process of completing additional qualifications in care, such as the national vocational qualification (NVQ) or the Qualifications and Credit Framework (QCF). Some staff had also completed specific training in falls prevention and awareness training with a company who assessed and addressed problems with poor eye sight. Staff had completed first aid training which included the use of a heart defibrillator. This was used in some situations when the person's heart had stopped and when staff were waiting for the arrival of the emergency paramedic team. The community nursing team were always available to give advice and had presented some training to staff around one aspect of a person's care when this was needed.

Along with signing up to a training agreement staff were expected to attend one to one supervision (support) sessions with either the registered manager or deputy manager. These regular meetings were a two way conversation between manager and member of staff and included the staff member's work performance, progress and training needs. Staffs' knowledge on key topics was checked at this point, for example, on safeguarding adult procedures. If needed additional training would be organised. Annual appraisals were

held with the registered manager and went through the progress made and discussions had throughout the supervision sessions. Staffs' goals, aspirations and areas for improvement were planned for in the coming year.

People had access to health care professionals when needed. The service worked alongside local community nurses and GPs to ensure people's health needs were addressed. Where needed people also had access to specialist health care professionals. Their care records recorded they had involvement from professionals such as: occupational therapists, speech and language therapist and mental health professionals. They also had regular access to foot, eye and dental care. One person had been referred to and had attended the auditory department at the local hospital for adjustments to their hearing aid. One person's records recorded a recent follow up visit by an occupational therapist and another person's had been seen by the dementia care nurse.

People had the support they needed to eat and drink and nutritional risks were identified, managed and monitored. People told us they liked the food and told us it was tasty, there was enough of it and it arrived "nice and hot". One person said, "The food's very good. I look forward to breakfast and lunch but I don't like too much after this, never have done". The food at Broadleas was cooked from scratch each day by the cook. We visited people in their bedrooms and they had a drink nearby with an additional supply to hand.

Food was provided to people in a way that they could manage it. For example, where people had developed problems with their swallowing, this had been assessed by a speech and language therapist and their advice had been followed. We observed one such person enjoy their food. They ate this independently from a bowl which contained food which was purposely soft. Red crockery was also used for some people to help them differentiate their dinner plate from a pale surface such as a table cloth or pale table top. This helped them locate their food more easily. People who required support from staff with feeding or just supervision received this quietly and in a dignified way. People could help themselves to fresh fruit and cold drinks which were set out in the lounge in a prominent position. We observed staff topping people's cold drinks up throughout the days we visited.

People's weight had been monitored and recorded and staff used a nutritional assessment tool to help them make a judgement on the action required if they lost or gained weight. There were recording mistakes on two weight and assessment records we looked at. The registered manager corrected these and said she would organise further training in the use of the nutritional assessment tool. Staff were aware of who had lost weight and they made sure additional calories were provided. This was done by fortifying foods with extra cream, butter and whole milk and reviewing what further support was required to help address this. Any weight loss or weight gain was reported to the person's GP. A decision about what else needed to be done to support the person was then made. For example, monitor more closely, make adjustments to medicines, for example if a person had gained weight due to water retention, referral for further medical tests, referral to a speech and language therapist or prescribe a nutritional supplement. All had been done at some point for various people.

We recommend that the service seek advice and guidance from a reputable source, about how best to reference consideration of the Mental Capacity Act when planning people's care.

We also recommend that the service seek advice and guidance as to whether further applications under DoLS are required.

Good

Is the service caring?

Our findings

When we asked one person about the staff they said "They are very kind dear. I think it's a good home". One relative said, "Staff are very friendly" and another said, "They are really kind staff". A visitor to the home said, "I come here almost daily and I have never seen or heard staff be nasty or abrupt". They went on to explain that they had seen some people, "get nasty with the staff" and said, "every time, they (staff) handle the situation so well. They are so patient and kind". They told us the registered manager was "exceptionally good" at "handling these sorts of "situations". They said, "She is just able to calm things down without a fuss".

One relative referred to the time they moved their relative in and told us how upsetting this had been for the whole family. They told us how pleased they had been with the support so far provided to their relative. They were also particularly pleased with the support and kindness shown to another relative (the person's next of kin). They said, "They (staff) were really helpful when we brought things in the day before for (name's) room. They were so kind". We also spoke with the next of kin who said, "They look after me as well. I'm finding it very difficult". This person told us the staff always asked them to stay and have a meal with them when they visited. The registered manager told us they were keen to ensure, that in these early days (of the person's admission to care) that the next of kin was also feeling cared for and was having a hot meal before they finished visiting. There was no charge being made for the meal.

We observed staff being caring and compassionate. One person was extremely upset at the decline in the health of a friend. Staff explained many times to them that the person had been admitted to hospital and they would keep them updated. This person could not retain this information so staff needed to repeat this several times over. However, it was done in the same caring and compassionate way each time. Staff showed compassion in the way they did this demonstrating that the person's upset really mattered to them. Staff gave their time, sat down with the person, spoke to them softly and put their arms around them when they got tearful. Later they supported the person to visit their friend in hospital. A taxi was ordered and one member of staff went with the person who would not have been able to do this independently because they were physically frail and confused. We were told the visit was upsetting but the person was pleased they had been.

We observed another interaction between one member of staff and a person who lived at Broadleas. The member of staff was aware this person sometimes needed encouragement not to self-isolate but was also aware people had the right to make their own choices. At lunch-time the member of staff tried to encourage the person to eat their meal in the dining room with others. This was done in a kind way by just suggesting the person may like to do this. The person said. "Oh no dear, I don't want to be around other people". This person then ate their meal quite happily on their own in the lounge. The same member of staff later encouraged this person to partake in an activity (word search) with the person sitting next door to them. To start with the person declined but a word search was left in front of them and eventually they picked this up and conversation with the person next door began. The conversation was animated between the two people and they enjoyed the activity.

Another person had severely reduced hearing ability. A white board had been used by the night staff to communicate with the person. We saw a message in large writing on it which said, "It's 1 am in the morning, would you like a cup of tea and then try to get some more sleep?". This showed staff were using an alternative and more appropriate way to communicate with this person in the middle of the night when it was quiet. It enabled them to help orientate the person to the time and show kindness in the way they helped them to settle.

Relatives told us the staff communicated with them well about any changes in care and gave them frequent updates when they visited or, if more urgently required, over the telephone. They spoke highly of the staff but said the registered manager was very good at doing this and was often around also at weekends "to have a chat" and "to catch up on things".

People's individual choices and day to day decisions were supported. People were able to get up and go to bed when they chose to. When people's mid-morning and afternoon tea was provided we saw some people had this in a mug and others in a tea cup with a saucer. The member of staff serving this told us they knew which each person preferred. A choice of biscuits was provided at these times and people could take as many as they wanted. People were given a choice of what they wanted to eat and sometimes this happened as the food was being served. People were able to alter their minds and staff helped to find something the person liked. One person told us the staff asked them what they wanted on that particular day for tea. They said, "They (staff) ask me what I fancy at the time and they go and get what I asked for".

People were provided with privacy and their dignity maintained. Staff spoke to people in a way which showed respect but also showed that a good relationship had been formed between the person being looked after and the staff. People's privacy was maintained during personal care which was always provided behind closed doors. If staff needed to address an emotional upset or speak to people about their care this was done quietly and privately. One person told us some staff were better at knocking on their door before they entered than others. We were with this person when a member of staff entered their bedroom. The staff member had knocked but not loudly and the person had not heard this. After talking about this observation with the registered manager they were going to talk to the person about the possibility of a door bell on their bedroom door which they may be able to hear better.

Relatives confirmed they were able to visit at any time and one person told us their visitor came at different times of the day which they were happy with. They told us they were always made welcome by the staff.

Good

Is the service responsive?

Our findings

People's needs were assessed and then their required care delivered in a way which protected people's individual rights and ensured their preferences and choices were respected. People were involved in this process if they were able and their representatives on their behalf where appropriate. Broadleas provided respite care (short stay care with a view of people returning home or being assessed for long-term care) to several people.

One relative told us they had not been involved in the planning of their relative's care or shown any care plans. However, they said, "I'm happy with (name's) care. Staff consult with me about the care they provide and about any changes they plan to make". They said, "We have had many talks about (name's) care". This person's advanced care plan recorded the person's wishes for the end of their life and the relative confirmed they had been involved in discussions about this. They had also been involved in the discussions held around whether the person should be admitted or not admitted to hospital when they had been poorly. It was understood that this decision ultimately sat with their relative's GP. Another relative told us they had not been involved in the planning of their relative's care but confirmed their relative's health had improved since they had been admitted to Broadleas. They had also been well consulted with about the progress being made. Another relative said, "(Name) does not look so anxious and agitated in the face". They seem to manage (him/her) very well".

People's care and social needs had been assessed prior to their admission so a decision could be made as to whether the staff could meet these. Relative's told us about the pre admission assessment process carried out by the registered manager. They told us the registered manager had visited their relative at home, spent a long time with them gathering the information she required. One relative said, "We discussed everything". The registered manager told us they were often approached by adult social care professionals to take people urgently. They told us they did not do this without an opportunity to assess the person first. A fairly urgent admission had been recently requested. The registered manager explained that the one free bedroom had been due to be refurbished whilst it was unoccupied. However, it was at the end of a week and the family of the person clearly required urgent support. Following a quickly organised assessment by the registered manager she agreed to the admission.

Planning for people's admissions was usually thorough and well thought out and individual circumstances managed well. This was demonstrated when we discussed the assessment and admission of two other people. The registered manager told us they had carried out an assessment of needs following a best interests decision by health and social care professional that the person required admission to a care home. On arrival the person had called out the entry code to their front door. The registered manager said, "We could have been anyone at the door and we were just able to walk in". The registered manager said, "We could not have left them there like that, they were so vulnerable". They liaised with the person's social worker and, with the person's consent, took them straight to Broadleas. This person told us, "I would not choose to live here dear; I would rather be in my own home if I had a choice, but they look after us both". This person had cared for their next of kin who had also required care at Broadleas. Staff had successfully responded to both of these people's personal needs and had considered and respected their right to a

private family life following their admission. This had involved supporting them to live in a way which best suited them within the care home setting.

Another person was due to be admitted once the refurbishment of their booked bedroom had been completed. The time waiting for this had been used to get the person used to the Broadleas. They spent two days a week spending time getting to know the staff, other people who lived there and join in with social activities and meals. The registered manager told us the feedback from the person and their family so far had been very positive and the person was looking forward to moving in. The staff aimed to respond to people's needs as well as they could. Sometimes this was in urgent situations and under difficult circumstances which required some thought to make it work successfully.

People's care was planned and recorded in their care plans. The provider's information received prior to the inspection had told us the registered manager had planned to improve how information was gathered and recorded about people's end of life wishes. For some people this had involved starting to complete an advanced care plan. It was planned that all their end of life care planning would be contained in one document, which if needed, would move with the person between services. It was however the intention of Broadleas to look after people at the end of their lives if this is what the person chose and it was possible to do so.

Care plans generally were maintained well, kept up to date and gave staff guidance on how people wanted their needs met. Although we had been told by people that they had not been involved in planning people's care the care plans were often very personalised. They recorded people's likes, dislikes, preferences and choices. Information gathered from the person, the relatives and through observations during the pre-admission assessment process had fed in to these. By also asking families to complete the Alzheimer's Society's Document "This Is Me" after admission and by further talking with people and observing them, staff gathered further information to be able to respond in a very personalised way to people's needs. The registered manager explained that it could take more than a few days to find out what people's real needs and abilities were, once they had been admitted to an unfamiliar environment. They said people take different lengths of time to settle so the initial care plan could alter quite considerably.

Two examples showed that people's on-going care needs, once identified, were planned in a very personalised way. One part of one person's care plan emphasised the person desire to be stimulated and kept active. The social activities record showed this person had been provided with regular opportunities to partake in social activities. Another person's personal care plan explained exactly what part of their personal care routine they found difficult. Staff had found approaching this person to provide personal care had been difficult. The care plan went on to record how staff were going to approach this. This was about building positive relationships and by slowly providing safe encouragement and a daily routine they hoped to help the person settle in and maintain their dignity.

People had opportunities to take part in social activities as well as one to one activities and conversation. A part-time activities coordinator had been recruited recently to help staff with the delivery of social activities. We observed an activity instigated by the care staff which had been an ad hoc decision. Nine people and one visitor joined in a word search and enjoyed this. We saw games and activity materials in the lounge for use, also a bookcase of DVDs and books. One person came in to the lounge and looked through the books, making a choice about what to read. People's records showed they had been involved in activities such as: listening to stories being read to them, playing games of skittles and attending tea parties held by the staff. Weekly music and movement sessions were held by an external person and each month a dog, through Pets As Therapy (PAT), visited people. A separate visitor also visited each day with their dog and people had become used to this and were attached to the dog. We were told a volunteer visited each Saturday and they

helped with providing people with drinks, played the piano in the lounge and chatted to people. The registered manager told us people also went out for regular walks or in their wheelchairs. They particularly enjoyed a fish and chip supper which some helped collect from the local take away. In the summer the garden was used for activities or just to sit in.

People were able to raise a complaint or concern, have this taken seriously and have it investigated and responded to. One relative told us they had not needed to make a complaint but said, "I feel she (registered manager) would follow up on any concerns or problems I may have".
The registered manager told us people were not given specific information on how to make a complaint but we saw the complaints procedure on the wall in the hallway. We reviewed the service's complaint log and one complaint had been received in the time the service had been registered under the new provider. This had involved a member of staff. This had been investigated and appropriate action taken to address this. We also read several of the many compliments received which included feedback from a family following their relative's death. It said, "You keep a lovely home, warm, clean and welcoming. They referred to their relative's end of life care and said, "such kindness".

Good

Is the service well-led?

Our findings

One relative said, "I think she (registered manager) is very approachable". A member of staff told us the registered manager was "very supportive". One person told us the registered manager visited them and was "lovely" and "very easy to talk to". We observed people responding well to the registered manager when they spoke with them and clearly they knew them and liked them.

The registered manager had very clear views on how she wanted people cared for and she communicated her values and expectations to the staff. The registered manager said, "The residents always come first". They told us they visited Broadleas at times when staff would not expect them to in order to make sure their values and expectations were promoted and acted on when they were not around. The registered manager had worked her way up through the care ranks and was very aware of what the job involved. A member of staff had been recently promoted to Deputy Manager and hoped to follow the same path the registered manager had taken. They told us they were receiving good support from the registered manager and company Director in order to improve their leadership skills and knowledge generally. They had completed a leadership course to enable them to better support the registered manager. Another member of staff confirmed that the registered manager was very supportive and approachable.

Communication was generally good and staff worked as a team. Staff were well informed about any changes in people's care. They received a handover at the beginning of each shift, one of which we observed. Who was to be responsible for various tasks and responsibilities was decided on before staff began their work. Staff competencies were monitored and checked by the management team and any poor practice addressed. The registered manager explained that if a staff member's probation time needed extending or a more established member of staff required additional performance management support then this was organised until they were happy with their competency and/or performance. The registered manager said, "For example, I would not expect to hear call bells sounding for a long time without a good reason". They explained that if this were the case they would investigate this straight away. They told us they were "always out and about the home" observing practices. When not "out and about" they were often working in their office into the evening and at weekends so they were very in touch with what was going on in Broadleas. One relative said, "I visit at all different times, weekdays and at weekends and (name of registered manager) always appears to be here".

Arrangements were in place to monitor the performance of the service against the provider's expectations and various regulations, including those set by the Health and Social Care Act 2008. Audits were completed by the registered manager who took action to address any identified shortfalls. We reviewed a selection of audits which included an audit of the kitchen and its performance and services, infection control audit and health and safety audit. As part of the registered manager's auditing and their consideration of the Key Lines of Enquiry (KLOEs) used by us (the Care Quality Commission) during inspections, they had identified a need for more formal involvement of people and their representatives in the reviewing of people's care plans. They told us this was an area that they had identified as needing improvement and intended to address this. This showed that the registered manager used their auditing processes and the guidance from the KLOEs to plan improvements to their compliance. A weekly report was also submitted by the registered manager to

the operations manager so they could monitor admissions, vacancies, levels of risks and risk management, complaints and staff sickness.

We were informed that more significant and longer term improvements were decided on by the senior management team collectively. This included the company Director/s, operations manager and the registered managers of both Cheltenham care homes (Broadleas and its sister home). A business plan was forwarded to us which recorded actions and completion dates for improvements planned between April 2015 and the summer of 2016. Those planned for before this inspection date had been met. These had included the kitchen improvements which were work in progress until January 2016, improvements to the outside footpaths and lighting, alteration of the three steps in the hallway, the creation of a focal point in the lounge which was a fireplace (this had been the choice of those who lived in Broadleas) following redecoration of the lounge and the creation of a wet room/shower room. The appointment of a part-time activities co-ordinator was in response to feedback from people and their relatives in 2015 where they said they could do with more activities. Also in that feedback had been a need to improve the food so menus and the quality of food purchased was reviewed with success.

The registered manager told us they felt well supported by the operations manager who was available for advice at any time according to the registered manager and who visited Broadleas at various times throughout the week. The operations director reported directly to the company Director. The registered manager also confirmed that the company Director visited weekly and was very accessible to talk with.

Information on best practice was gathered from visiting health care professionals, by the registered manager keeping their own training and knowledge up to date and by networking with the registered manager of the sister home. The service did not have any links with external groups such as the Alzheimer's Society which the registered manager agreed would be beneficial.