Broome End Ltd

Broome End

Inspection report

Pines Hill
Stansted
Mountfichet
Essex
CM24 8EX

Tel: 01279816455

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Broome End on 12 July 2017. Broome End is registered to provide personal care and accommodation for up to 37 older people, some of whom are living with dementia. The service is spread out across three floors with communal lounge and dining areas located on the ground floor. The service has an extensive secure garden area which people are able to access if they choose. When we visited there were 27 people living at the service.

We last inspected the service on 26 April 2016 and rated the service as requires improvement. This was because we had some concerns around low staffing levels, especially at night, and the lack of support given to the registered manager. During this inspection we found that although some improvements had been made to the management structure of the service we continued to have concerns about low staffing levels at night and a high reliance upon agency staff resulting in a lack of cohesion amongst staff.

At the time of the inspection there was not a registered manager in post. Since the previous inspection a new home manager and deputy manager had been appointed. The new manager was in the process of registering with the commission. 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.

Whilst care plans were person centred and detailed in places some lacked specific information about people's care. This meant that they did not consistently reflect the needs of people and at times staff lacked guidance on how to minimise potential risks.

A high reliance upon agency staff meant that people could not be assured that they were being supported by staff who knew them well. Consequently, people did not always receive care and support that was suited to their individual needs and preferences. Staff were not always deployed effectively to meet people's needs and at meal times there were not enough staff available to support people to eat and drink in a dignified manner.

Effective systems were not in place to ensure that medicines were consistently stored and managed safely.

Staff had completed a variety of training modules. However, they were largely provided through on line sessions and there was no evidence to show that following the training staff had their competencies assessed to ensure that they had understood what they had learnt and were able to effectively apply it to their daily practice.

Whilst staff were caring in their approach limitations on their time meant that the care provided was largely task focussed. Some people participated in a variety of activities however, people with a greater need were left for periods of time with little meaningful stimulation or interaction.

Whilst systems were in place to monitor the quality and safety of the service records showed that they had not always been used effectively. This meant that the management team did not have a clear oversight of the service.

Staff understood how to recognise signs of abuse and were confident in the action that they would take to raise any concerns.
The service had a recruitment process in place to ensure that staff were safe to work with people living at the service.

Staff worked in line with the principles of the mental capacity act and understood their responsibilities to ensure people were given choices about how they wished to live their lives.

The manager and deputy manager were a visible presence around the service and supportive and accessible to staff. Together they had worked hard to develop effective working relationships with local healthcare professionals.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Care plans were person centred and detailed in places but some lacked specific information about people's care.

Safe recruitment practices were followed.

Regular safety checks of the service were completed to ensure that it was safe for people to use.

Effective systems were not in place to ensure that medicines were consistently stored and managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had completed a variety of on- line training modules but their competencies had been assessed to ensure that they had understood what they had learnt and were able to effectively apply it to their daily practice.

Staff were not effectively deployed to support people to eat and drink in a dignified manner.

Staff understood their responsibilities to ensure people were given choices about how they wished to live their lives.

Is the service caring?

Requires Improvement

The service was not always caring.

A high reliance upon agency staff meant that people could not be assured that they were being supported by staff who knew them well and could meet their care needs.

Whilst staff were caring in their approach limitations on their time meant that the care provided was task focussed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people took part in variety of activities however people with a higher level of need were left for long periods of time with little meaningful; stimulation.

Complaints were well managed and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

At the time of the inspection there was not a registered manager in post.

Staff felt well supported by the manager and the deputy manager.

The management team had developed effective working relationships with local healthcare professionals.

Quality assurance systems were in place but had not always identified areas for improvement.

Broome End

Detailed findings

Background to this inspection

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

This inspection took place on 12 July 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience whose area of expertise was in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service, including notifications of incidents that the provider had sent us and previous inspection reports. A notification is information about important events, which the service is required to send us by law. We also reviewed the Provider Information Return (PIR), which was completed by the provider prior to the inspection. 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.

To help us gain an understanding of people's experiences of living in the service we observed the interactions between people and staff and saw care and support being provided. We looked at four care plans and associated care documentation and at how medicines were managed. We also looked at documentation relating to the management of the service including policies and procedures, staffing rotas covering the last six weeks, staff training records, a range of audits and the results of quality assurance surveys. We reviewed four staff files to see whether staff had been recruited safely and looked at complaints and compliments received by the service.

We spoke with 13 people living in the service and four relatives. We also spoke with three agency care workers, the activities co-ordinator, a kitchen assistant and two visiting healthcare professionals. We spent time with the home manager and the deputy manager discussing the running of the service. After the inspection we also spoke with one permanent staff member and contacted another healthcare professional who visited the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe living in the service. One person said, "I do feel safe here as I can go out into the garden on my own and there is a new fence up now so no one can get in." Another told us," I do feel safe here but I cannot tell you why, I think it is because I can tell someone if I am worried." Relatives commented, "I think [relative] feels safer here. [Relative] now feels this is more [their] home."

The service had a policy in place for the management of medicines. This included the ordering, storing and return of any unwanted medicines to the pharmacy. To ensure that medication remains safe to use it is important that the temperature of the room that it is stored in is regularly monitored. Although staff told us that the temperature of the medication store room was monitored on a daily basis and remained within the safe parameters on the day of the inspection staff could not find the log book where this was recorded. There were records to show that the temperature of the medication trolleys had been monitored. However, whilst the recordings were within safe limits there were gaps in some of the records. For example, one of the trolleys had no temperature recording for the 4, 5 or 7 July 2017 and on both the 4 and 5 July 2017 staff had signed the form but not recorded a temperature for either day. This meant that we could not be confident that staff were always correctly monitoring the temperature of the medication store room.

We completed a stocktake of medication and found that people's medication administration records (MAR) were not always accurate. Although all of the medication could be accountable the numbers recorded on the MAR sheets did not always tally with the amount left in stock. For example, one person was prescribed paracetamol to take as required (PRN). According to their MAR sheet they should have had 91 tablets left but when we counted them there were 87 tablets left in the box. When we looked into this further we found that staff recorded PRN medication on a separate form which confirmed that the four missing tablets had been administered to the person but staff had omitted to record this on the MAR.

In order to be able to calculate the expiry date of medication provided in liquid form staff should record the date that the bottle was opened. We found two bottles opened but with no opening date on them which showed that this was not consistently being done.

Medication profiles were in place for each person living in the service and contained information about any drug allergies and an up to date photograph of the person. However, there was no guidelines for staff about how people liked to take their medication. The service had a protocol in place to guide staff when people needed to take medicines as required (PRN) and for the administration of homely remedies. Homely remedies is another name for a non-prescription medicine used in a care home for the short term management of minor, self-limiting conditions, such as toothache, cold symptoms and headaches. However, staff had not recorded any specific detail about the medication that had been administered and two different people had been recorded on the same sheet which meant that it was not possible to maintain a stock balance. Some people had also been prescribed topical creams, however application records were not consistently completed and did not record how frequently or where on the body the cream should be applied. We also did not see any body maps for people who had been prescribed transdermal patches. Transdermal patches are medicated adhesive patches that are placed on the skin to deliver a specific dose

of medication through the skin and into the bloodstream. Placing a new patch in the same place as the old one may irritate the skin; therefore it is good practice for staff to use body maps to show where on the body previous patches have been placed. Staff assured us that they were using body maps to record the placement of transdermal patches but they were unable to locate them during the inspection. We discussed our findings with the manager and suggested a review of how staff recorded homely remedies and PRN medication to ensure that records were accurate.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was receiving covert medication. Records showed that a mental capacity assessment had been completed and the GP supported the decision. There were also clear guidelines for staff about how to administer the medication. Covert medication is when staff administer medicine without the person's knowledge by disguising it in food or drink. This is only possible if a person has been assessed as not having capacity and with the authority of an appropriate healthcare professional, such as a GP.

People taking Warfarin were supported to do so safely. Their International Normalised Ratio (INR) was clearly documented in their care plan and the Warfarin stock was accounted for in the medicine cupboard. People taking warfarin are required to have their INR regularly monitored in order to measure the clotting ability of their blood and to monitor the risk of bleeding.

Staff told us that they had received medicine training and had their competency assessed to ensure they had the skills and knowledge to support people safely with their medicines. Records confirmed that staff competencies had been reviewed and that weekly medication audits were completed. However, the medication audits had failed to identify all of the problems that we identified during the inspection.

Records showed that all care staff had completed training about how to safeguard people from harm. The staff that we spoke with demonstrated an understanding of how to recognise different signs of abuse and knew how to report any worries or concerns both within the service and, if necessary, to external organisations.

Risks associated with people's day to day care needs were assessed and care plans contained guidance for staff about how to manage risks or to mitigate the potential for reoccurrence. However, whilst care plans were person centred and detailed in places some lacked specific information about people's care and therefore did not reflect their current needs. For example, one person living at the service had a respiratory condition, their care plan stated that their oxygen saturation levels should be monitored on a daily basis but this was not happening. Oxygen saturation is a way of measuring how much oxygen the blood is carrying and can be used to monitor the health of a person with a condition that affects blood oxygen levels such as respiratory and cardiac disease. We discussed our findings with the manager and the deputy manager who informed us that the person's condition had improved and it had been decided that daily monitoring was no longer needed. They went onto say that staff knew the person well and understood what signs to look out for if they were in respiratory distress. We were told, "Everyone knows. Staff are quick to say if something is not right." However, the person's care plan did not include any information for staff about what their normal saturation level should be or of the signs and symptoms that would indicate that the person's saturations were low. This was a particular concern given the reliance of the service on agency staff who may not have known the person well. We spoke with the manager and the deputy manager about our concerns who reassured us that they would amend the persons care plan.

Systems put in place to monitor people safe and keep them safe were not always effective. For example, the

deputy manager monitored the incidence of falls in the service. They explained to us that they were hoping to develop the process further to enable them to analyse the information and use it to reduce the risk of reoccurrence, "I want to develop something that shows me a pattern. Falls are going down. It's been helped by the involvement of the falls prevention team and more detail in care plans. Two people who were falling out of beds now have bedrails." However, some people living at the service had poor skin integrity which placed them at risk of developing pressure wounds. Repositioning charts had been implemented to minimise this risk however, staff were not consistently completing the charts. One person's care plan stated that they needed to be repositioned every two hours during the day and four hours at night. When we reviewed their charts between 5 to 12 July 2017 we saw that there was no 24 hour period during which this had happened. On 8 July 2017 staff had only recorded one turn over a 24 hour period and on the 7 and 10 July 2017 there were no recorded turns.

Regular safety checks of the service were completed to ensure that it was safe for people to use. Water taps were fitted with thermostatic mixing valves and the temperature of the hot water was regularly checked to ensure that it remained within a safe range. Fire safety checks were completed and personal electrical appliance (PAT) testing had been carried out to ensure that electronic equipment was in safe working order. The electronic call bell system, window restrictors and bedrails were all reviewed on a weekly basis to ensure that they were in good working order and we saw that any issues raised had been addressed.

On the day of the inspection we found that staff were not deployed effectively to meet people's needs and the service continued to rely upon agency staff to back fill vacant posts. Three out of the five care staff on duty were agency staff and it was evident from their actions that they did not all know people well which had a direct impact upon staff cohesion. On the day of the inspection inspectors found it difficult to speak directly with the permanent care staff because they were busy providing care and directing the agency staff and we observed several periods during the day when people were left unsupervised in the communal areas. One relative said, "At weekends there are hardly any staff around who are visible. You have to hunt someone down. There are a lot of agency staff working at weekends." Another relative told us, "I do feel my [relative] is safe here, and have no concerns, but there is not always enough staff on duty, and there always appears to be agency staff here." One staff member told us that it was stressful working when the service relied on agency staff to back fill staffing vacancies but they felt that this was now improving. Another said, "We are not there yet. We did have really good staff retention but some staff are now leaving."

As at the previous inspection we continued to have some concerns about staffing levels at night, particularly in regard to how staff would manage in the event of an emergency. Records showed that three staff were rostered onto the night shift, which started at 8pm. This meant that there was one staff member allocated to each unit overnight. However, one of the units was spread across two floors and staff were unable to access one side of the first floor of the service from another. We spoke with an agency staff member who had worked a night shift who felt that the staffing levels were sufficient. However, staff working the night shift were entitled to half an hour break and there were some people who required the assistance of two staff with manual handling and personal care. This meant that there were periods of time during the night when units were left unattended. We discussed with the provider that the logistics of the building rather than the number of people living in it meant that the staffing levels at night were a concern. They informed us that the issue had not been raised by staff or people living in the service and there had been no evidence that there had been any detrimental impact upon people. They also assured us that as the number of people living in the service increased, the staffing levels at night would be increased to reflect this. We also saw that an emergency contingency plan was in place with a contact list detailing who should be contacted in the event of an emergency, such as a fire. This included specific information for the night staff regarding how to contact staff who lived close to the service, the fire marshall and the home manager if additional staff were required and details of other local services where people could be evacuated to if the need arose.

Robust systems were in place to ensure that staff were recruited safely. All the required employment background checks, security checks and references were reviewed before staff began to work for the organisation. This process ensured that the provider made safe recruitment choices. We looked at the recruitment files of four staff members. Each file contained a copy of the member of staff's contract of employment and proof of identity. Prior to starting employment, new employees were required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

A heavy reliance upon agency staff meant that there were not always sufficient numbers of suitably experienced staff to provide care in accordance with people's wishes and needs. One person told us, "Some staff know what they are doing but we have a lot of agency staff here you have to tell them what to do." A relative said, "You see a lot of different staff here so I am not sure if they really know the residents." At lunch time we spoke with an agency worker who was assisting a person with their meal. They told us, "I do not know this [person] I am feeding." They went onto say, "Well I saw [them] yesterday throwing her food on the floor so I just thought I would feed her today".

Records showed that staff had completed a variety of training modules. However most of the training was completed on line and there was no evidence that staffs competencies had been assessed following the training to ensure that they had understood what they had learnt and were able to effectively apply it to their daily practice. One staff member told us, "Most of the training is on-line. I'm not a fan. We did have someone come in to do first aid." Face to face training had been arranged for pressure mattresses and bedrails but the person delivering the training had cancelled and at the time of the inspection it had yet taken place.

New staff members completed a two week induction programme when they joined the organisation. As part of the programme new starters worked alongside more experienced colleagues before they provided care for people. This ensured that new staff members became familiar with people's needs and how they wished their support to be delivered. In addition to this, to ensure that new members of staff had the correct skills and abilities to fulfil their roles, they were required to complete a three month probationary period. The probation period is a period of time during which the employer is able to assess a new staff member's ability to meet certain performance levels. However, on the day of the inspection there were a large proportion of agency staff on duty and we had concerns about how they were supported to get to know the needs of the people that they were supporting. Whilst the deputy manager told us, "With agency they have an induction and I'll watch them." When we spoke with agency staff they told us, "We get induction. Not so much about the residents. It's about the fire escapes, security, where things are." And, "To be honest I ask. If I'm asked to give personal care I ask if there is anything I need to know. I have to ask otherwise I'm just thrown in."

We saw evidence that annual appraisals of staff performance had been completed and that staff had access to regular formal supervision sessions. The manager had used these sessions to address issues with staff as they arose and to highlight areas where additional training was required.

Records of handovers showed that they were used to continually prompt staff when records had not been completed as expected and for the deputy manager to pass on any actions from the monitoring of the care plans to staff. For example if people's weights had dropped significantly and they needed to be weighed again or to prompt staff to promote staff if fluid intake was low.

Some people living in the service were not consistently able to make important decisions about their care and how they lived their daily lives. The MCA provides a legal framework for making particular decisions on

behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

Records showed that staff had completed training in respect of the MCA and DoLS. All the staff we spoke with understood their responsibilities to ensure people were given choices about how they wished to live their lives. Where people did not have the capacity to consent themselves we saw that the service had operated in line with the requirements of the MCA. We spoke with staff about how they supported people who had difficulty making choices in their daily life and how they communicated with people in a way that they understood what was being asked of them. One staff member told us, "There is one person who is easily distracted. So I show them options like different clothes after a bath or we plate up two dinners, then they can make a choice much more easily." Another person had been requesting excessive amounts of coffee during the day leading to a poor sleeping pattern and the person becoming agitated if staff limited the amount. Staff were concerned that they did not have the insight to understand the impact of this upon their health. A capacity assessment has been completed and an action plan implemented whereby the person was given decaffeinated coffee which had resulted in them having a better night sleep.

Nutritional assessments had been completed and where people were found to be at risk of malnutrition the service monitored their food and fluid intake. Staff used the Malnutrition Universal Screening Tool (MUST) to monitor people's weight on a monthly basis and we saw that comments were made about the person's score and any action that needed to be taken. People who had been identified as being at risk of weight loss were weighed weekly and the deputy manager analysed the information to ensure that the appropriate referrals were made to the relevant health professionals.

At lunch time we observed that staff were not always deployed appropriately to effectively support people and that people's meal time experience varied according to which staff member was assisting them. We saw some staff members chatting pleasantly to people, promoting their independence and asking if they were enjoying their meal. However, we also observed other staff members assisting people without any social interaction. One person told us, "I take my meals in my bedroom as no one really chats at meal times." We also observed an agency staff member standing over a person whilst helping them with their meal. They were spoon feeding the person and not giving them time to finish a mouthful before offering the next spoonful. There was no conversation attempted with the person and on leaving the person and returning the agency worker was heard reprimanding them when they saw they were putting food on the floor by saying, "Why are you putting it all over the floor?" We spoke with the management team about our observations and they assured us that they would address the issue with agency worker and the agency and not have them return to the service.

Staff supported people to access healthcare professionals when needed. One person told us, "I had a hospital appointment in the week and a carer came with me." Another person said," I had to go to hospital recently about my eye and a carer came with me, she was very nice and kind to me." Care records showed that people had regular reviews from opticians, chiropodists and the dentist. Staff noticed and responded promptly to people's changing health needs and visits from the GP and referrals to other specialist healthcare professionals for additional advice and support had been made in a timely manner. For example, one person had recently had a fall. Records showed that they had been reviewed by the district nurse and staff had placed them on the GP list to review that week with a view to referring them to the falls clinic. Another person had been seen by audiologist. Their care plan contained a clear explanation of how their

new hearing aid worked and how it should be fitted. During and after the inspection we spoke with three healthcare professionals who supported the service all of whom confirmed that staff were vigilant at implementing the advice that they provided for people. One visiting healthcare professional told us, "So far they have been implementing all of the things we would advise." Monitoring systems were in place to ensure that pressure relieving equipment was used correctly. For example, we checked the settings on the pressure relieving mattresses and saw that they were set at the correct pressure for people.

Some of the environment downstairs had recently been updated and decorated and the manager explained that there were plans for further work to be carried out in the future. However, the 'dementia unit' was located upstairs in the service and was not designed to meet the needs of people living on the unit. Despite being occupied several of the bedroom doors did not have people's names on them or memorable objects outside them to assist people in identifying their rooms. The walls were bland and there was poor signage with no visual signage to help identify toilet doors and there were no coloured toilet seats or clouded crockery in place. Contrasting colours are recommended to help people with a cognitive or visual impairment define objects more clearly. For example, using coloured rubber mats and/or crockery that contrast with tablecloths helps to define the edge of plates and dishes and might be helpful for some people and toilet seats in colours that contrast with the toilet and with other nearby surfaces can help make them more visible and identifiable. One relative told us, "The maintenance side of things needs stepping up. [manager] is aware and things do get sorted out when asked." The manager told us that there were on going plans around the development of the building,

Requires Improvement

Is the service caring?

Our findings

On the whole, people, their relatives, and staff spoke highly of the care that they received. One person told us, "I'm very well taken care of." Another person said, "The staff are caring and I can decide what I like to do but they do not talk to you much." However, other people and relatives expressed concern about the services reliance of agency staff and the impact that this had on the care that people received. One person told us, "I was born in Chile, but no one ever asks me about my life, I eat the food here but really not my sort of food."

People told us that they were able to make choices about their day to day care, such as the time that they got up, what they wore and what they ate and drank. We observed that the individual staff who supported people were kind and caring and treated people with dignity and respect. We heard one staff member ask a person, "Are you warm enough? Would you like a sheet or something? Do you want your legs to come up?" On the whole the atmosphere across the service was calm and we heard staff speaking to people in a pleasant and kind tone. One staff member told us, "I love it here to be honest." Throughout the inspection we saw that doors were closed during personal care and staff knocked and waited to be invited in before they entered people's room. On the day of the inspection the hairdresser was present. They had clearly knew people well and had built up a good rapport with people and we heard them chatting to people about topics that they were interested in. At times they became the social hub of the home.

However, whilst staff were caring in their approach limitations on their time meant that the care provided was often task focussed and there was little time for social interaction with people. For example, a birthday cake was bought out in the afternoon for a person's birthday. Whilst this was a nice gesture rather than making it a special occasion the cake was presented it to them in the corridor rather than at tea time when other people would have been present. One person told us, "Some staff are caring, some just do their job, but you see different ones so they do not really know much about you." A relative said, "My [relative] is supposed to have different shoes on sometimes but despite saying to them they put the same ones on. But having different staff is not easy."

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and support that was suited to their individual needs and preferences. Whilst care plans were person centred and detailed in places some lacked specific information about people's care. This meant that they did not consistently reflect the needs of people and at times staff lacked guidance on how to minimise potential risks.

We received mixed feedback from relatives regarding their involvement in planning people's care. Some relatives told us that staff kept them up dated on any changes in their relatives needs and that they were involved in developing their loved ones care plans. One relative said, "They do without a doubt. We get together and discuss." Other comments included, "They do without a doubt. We get together and discuss." And, "I come in every other day they do update me on any changes to my [relative]." However, another relative told us, "I have had one odd meeting here but they do not have them regular. I have not been asked about a care plan."

There was a strong smell of urine and we saw dirty bed linen in one of the bedrooms. Staff told us that there was a rota in place for changing people's bed linen; however this needed to be more person catered to ensure that the needs of people were met. We spoke with the management team about this and they arranged for the bedding to be changed.

The service had an activities co-ordinator in post and in the afternoon one of the kitchen assistants assisted with activities. The activity staff knew people well and spoke with us about individual's likes and dislikes and activities that they enjoyed participating in. One relative told us, "[Staff] are always friendly. [Activities co-ordinator] is very good at organisation of events. That's really stepped up." During the inspection we observed some people socialising in the garden laughing and chatting together and taking part in archery. In the afternoon some people were also involved in making jam for a fete taking place at the service at the weekend. However, we observed that other people spent much of their time just sitting in the lounge with the television or music on without meaningful engagement. We heard one person asking, "I don't know what to do. Where is everyone?" When we asked them if there was much for them to do they replied, "Not a lot." In addition to this we had concerns that people who remained in their own rooms or who chose not to or were unable to join in group activities were placed at risk of social isolation because it was not possible for staff to spend time with them. The activities co-ordinator told us, "I try to do different activities here but can be difficult to give time to all. I always download the newspaper each morning and give it to those who I know will read it and then we have a chat about it. I also give a word search to some residents who like to do them. There is not always the time to give one to one time activities". During the inspection we observed one agency worker who was in the communal area for much of the day. They did not attempt to engage with people and spent much of their time standing in the middle of the room watching the television. We spoke with the management team about our findings and they assured us that they would address the issue with agency.

People and their relatives knew how to raise any concerns or complaints. One relative told us, "Yes I have complained about a couple of small things and they were sorted out". Another said, "I did complain about

his room not being cleaned but it was all put right. "The service had a complaints procedure in place. We looked at the complaints log and found that they had been investigated and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff were complimentary about the manager and deputy manager and described them as sportive, approachable and visible around the service. One relative told us, "It's getting better. They seem more organised. Things are being modernised. There is the provision of more things to do and the food has definitely improved. They are working hard to bring things up to speed."

Whilst systems were in place to monitor the quality and safety of the service records showed that they had not always been used effectively which meant that the management team did not have a clear oversight of the service. Audits had been completed in areas including infection control, medication and people's dining experience but they had not captured all of the issues that were identified during the inspection. We saw that in some incidents issues raised as a result of the audits had been addressed promptly. However, in other areas the audits had not been in depth enough and had failed to identify areas for improvement. For example, during the inspection we noted that some areas of the service would have benefited from more in depth cleaning and in the bathrooms hoist slings had been stored directly above dirty laundry bins. One relative also told us, "Sometimes rooms are not as clean as they could be. The cleaning could be stepped up a bit." None of these issues had been identified during the manager's environmental audits of the service. This meant that the manager had not taken adequate steps to monitor and improve standards and ensure that people living in the service were kept safe and receiving care which met their needs.

Improvements had been made to the management structure and a deputy manager had been appointed to support the new home manager. The manager and deputy manager had an effective working relationship and had worked hard to establish good relationships with local healthcare professionals which had previously broken down. The manager told us, "We work as a team now with the outside agencies." One healthcare professional told us, "I have nothing but praise for the care and leadership in Broome End since the change in management. There always appears to be sufficient staff and they accept and take on board any and all of our advice. The residents are much happier and look well-nourished and cared for and the home is more of ' their home." Another visiting healthcare professional told us, ""Previously there was a lack of leadership and management now that is definitely not an issue. Patients are getting much better care as a result. [Deputy manager] always knows what's going on. We used to find information was inconsistent. They are now able to answer my questions so much better."

Staff were positive about the new management structure and told us that they felt well supported by both the manager and the deputy manager. Everyone that we spoke with described the management team as visible and approachable and were confident that issues raised with them were promptly addressed. One staff member said, "If something happens at work you can always speak to them and ask for help."

Monthly staff meetings were held and we saw that the manager had developed action plans to address issues raised following the meetings. Regular resident and relative meetings also took place and we saw that the manager had responded to feedback received during the meetings. We looked at the minutes from the last meeting held in May 2017. Concerns had been raised that the reception area was left unsupervised at weekends. In response to this the management team had installed an on call rota which ensured that one of

them would be present in the office over the weekend.

The manager understood their responsibilities to the Care Quality Commission (CQC). They reported significant events such as safety incidents, in accordance with the requirement of their regulation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure that medicines were consistently stored and managed safely.