Broome End Ltd

Broome End

Inspection report

Pines Hill
Stansted
Mountfichet
Essex
CM24 8EX

Tel: 01279816455

Date of inspection visit:
28 April 2016

Date of publication:
29 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 28 April 2016 and was unannounced.

The service provides accommodation for up to 37 older people some of whom may be living with dementia. At the time of our inspection 26 people were living at the service. We last inspected the service on 16 July 2015 in response to concerns that had been raised with us. At that inspection we rated the service Requires Improvement but did not carry out a fully comprehensive inspection. This inspection was carried out to check on the improvements we required and look at areas of the service not previously checked.

A registered manager was in post. 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.

Staff were trained in keeping people safe from abuse and understood their responsibilities should they suspect abuse had occurred. Staff were able to outline how they would report any concerns they had.

Risks to people's health and wellbeing were assessed and reduced as much as possible.

Staffing levels were sometimes low, especially at night, and did not always reach the level the service had assessed as safe.

Medicines were well managed and regularly audited.

Staff received a structured induction and training was provided to equip them to carry out their roles. Experienced staff demonstrated a good knowledge of the people they were supporting and caring for and knew people's particular preferences and wishes with regard to their care.

We saw that staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. Staff demonstrated a basic understanding of the principles of the MCA and DoLS.

People who used the service were very positive about the food and were able to exercise choice about their meals. Mealtimes were sociable occasions which people greatly enjoyed. People identified as being at risk of not eating enough were referred to appropriate healthcare professionals and monitored.

People were supported to access healthcare professionals when they needed them and the staff involved relevant professionals when a person's health declined. The GP expressed concerns that sometimes the service did not alert them promptly enough when someone became unwell and sometimes information about people's health was not accurate. The district nursing team also had concerns and there was a poor relationship between them and the manager of the service which had the potential to place people at risk.

Staff were caring and committed and we saw that people were treated respectfully and their dignity was maintained. The atmosphere was of a friendly place and the good relationships between staff, the people they were supporting and visiting relatives were observed throughout the service. Relatives were very positive about the caring nature of the staff.

People, or their relatives, were involved in assessing and planning their care and plans were regularly reviewed.

People were supported to follow different interests and hobbies and to go out on trips. People living with dementia and those who did not wish to take part in structured activities were provided with one to one sessions.

There had been no formal complaints but informal complaints were logged and investigated in line with the provider's complaints procedure, and to people's satisfaction.

The service had an open culture and the manager was approachable. The manager was not supported by a deputy, and had not had consistent support for over a year. The provider had not taken steps to successfully address this which was a concern as the issue of the breakdown in the relationship with the district nursing team had the potential to place people at risk and the manager was dealing with this on their own.

An effective and wide ranging audit system was in place and records were well organised and easily located.

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.

Procedures were in place to protect people from abuse and staff had been trained to recognise the signs of abuse and knew what action to take in response to concerns

There were not always enough staff to meet the needs of the people who used the service, especially at night.

Medicines were managed safely.

Risks were assessed and measures taken to reduce them.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received the induction and training they needed to carry out their roles.

Staff had received training regarding the requirements of the MCA and DoLS and showed an understanding of the basic principles.

People were mostly well supported with their eating and drinking, although sometimes recording was not detailed and meant that changes in people's weights might not be identified promptly.

People had good access to healthcare support and we saw evidence of many healthcare professionals providing support.

The local district nursing team had concerns about the way the service managed people's health and the relationship between the service and the district nursing team was deteriorating which placed people at potential risk of harm.

Is the service caring?

Good

The service was caring.

Staff were very caring, kind and compassionate and they treated people with respect and maintained their dignity.

People, and their relatives, were encouraged to express their views and were consulted on aspects of their care.

Is the service responsive?

Good

The service was responsive.

People were involved in assessing and planning their own care.

People were able to follow their own interests and hobbies. One to one time and meaningful occupation was provided for people living with dementia or those who chose to remain in their rooms.

The service was very proactive in asking for feedback and responded to any informal concerns raised promptly and to people's satisfaction.

There had been no formal complaints but a complaints system was in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

People, and their relatives, were involved in developing the service and praised the open culture and the approachability of the manager.

The manager was not supported by a deputy and the provider was not proactive about supporting the manager to address the serious issue of the poor relationship with the district nursing team.

The service had an effective and wide ranging audit system in place.

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.

The inspection took place on 28 April 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for someone who used this type of service.

Before we carried out our inspection we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law. We also looked at previous inspection reports.

We spoke with 12 people who used the service, two relatives, six care staff including senior staff, the registered manager, the facilities manager and the provider. 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 easily or chose not to. We also spoke with staff from Essex County Council with responsibility for safeguarding, quality and improvement and contracts. We gathered feedback from the local GP and the district nursing team.

We reviewed six care plans, three medication records in detail and three further records were spot checked, four staff recruitment files, staffing rotas for the weeks leading up to the inspection and records relating to how the quality and safety of the service was monitored.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service and appeared to be at ease in the company of the staff. One relative described this to us saying, "We are very pleased with everything here and [my relative] is certainly safe and well looked after". People who used the service commented positively about feeling safe. One said, "Yes I feel safe and the staff are lovely" and another stated "It's very comfortable and I feel very safe. I am happy here".

We found that systems were in place to reduce the risk of abuse and to ensure that staff knew how to spot the any signs and symptoms of physical, emotional and psychological abuse and take appropriate action. Staff were able to tell us what they would do if they suspected or witnessed abuse and knew how to report issues both within the company and to external agencies.

Staff had received training in safeguarding people from abuse and the manager was clear about their responsibilities related to keeping people safe and had reported matters to CQC appropriately. Before the inspection the manager had contacted us for advice about how to ensure one particular resident's safety as they needed one to one staffing in order to keep them safe and that was not funded for them. We saw at this inspection that the manager has liaised with relevant professionals and the additional support hours were now in place to protect this person.

We saw that risks were assessed and actions were taken to reduce these risks as much as possible. We saw that people's risks associated with their daily activities such as eating and drinking, personal care, mobility and their likelihood of choking or having a fall had been assessed. Risk assessments had not always been appropriately reviewed which placed people at potential risk of harm. We noted that some people had their call bells out of reach. We asked one person how they would get help if they needed it and their responded, "Well that's the question isn't it?" Although this person was independently mobile we observed that they would have struggled to open their door, come out of their room and attract staff attention easily if they needed assistance.

Specific risks had been given consideration. For example it had been identified that one person was intending to do a parachute jump and staff had begun to involve healthcare professionals to risk assess this activity. The service had a business continuity plan which set out how the service would continue to operate in the event of major emergencies such as fire or flood for example. We saw that this plan contained detailed and clear advice for staff to follow. We also noted that staff had a walk round with the person responsible for maintenance when they began their induction and were shown all the gas and water cut off points. There were risk assessments in place regarding legionella infection and fire. Each person had an individual emergency evacuation plan for staff to follow in the event of a fire.

People had been provided with equipment to reduce risks associated with pressure care and mobility and we saw that measures, such as regular repositioning of people and application of creams, were in place to reduce the risk of people developing pressure ulcers. Charts we saw indicated that people had received the required repositioning to help prevent pressure ulcers. Sensor mats were in place to alert staff if a person,

who is at risk of falling, had left their bed and was moving about independently in their room. We saw that one person had a profiling bed set at the lowest setting and staff checked the person, who was predominantly nursed in bed, every 30 minutes. Indeed the person said to us, "Sometimes they check me too often!"

Although these measures were appropriate and designed to reduce these risks for people the low staffing numbers and design of the building meant that we could not be assured that staff would be able to respond quickly if a sensor alarm was set off.

People who used the service, and their relatives, told us that they felt the staffing levels were sufficient to meet their needs. People told us that they did not have to wait too long a time when they pressed their call bell. One person said, "If I press my buzzer the carers come as quickly as they can." Another person commented that thy could no longer press their call bell as they did not have the strength but were reassured as staff look in on them regularly to see if they need anything. Most people commented on how very busy the staff were and we saw that the layout of the large building made it difficult to establish where staff were sometimes.

We asked to see the call bell response audits for two randomly chosen days and found that call bells had been answered promptly over a twenty four hour period on each of these days, with most calls being answered within one or two minutes.

Staff told us that they found the staffing levels did not always enable them to deliver care as quickly as they would have liked. The manager told us that staffing levels had been determined according to people's needs. Staffing during the day should be two senior care staff supported by four care staff and at night this reduced to one senior care staff and two care staff. We were concerned about the low staffing levels for the night shift in particular, especially as the shift began at 8pm which would presumably mean that many people would still be up and would need assistance to go to bed after this time. We examined rotas for the eleven weeks leading up to the inspection. Records were hand written and not always clear, however we could identify that the service was not always meeting the assessed staffing levels.

The service had assessed that during the day six care staff were required to meet people's needs, with two of these being senior staff. We saw that throughout the eleven week period some shifts had taken place with five and once only with four staff on duty. Having become familiar with the layout of the building, which is divided into two halves, we could not be assured that this level of staffing would ensure that people's needs would be met promptly.

We also noted consistent levels of staff sickness which affected each of the weeks of the eleven week period. Five of the eleven weeks had more than three staff off sick and one had five staff off. Often staff worked long days which covered the period from 8am to 8pm. The service used staff from local agencies to cover these hours. Although it was clear that some staff agency worked regularly at the service it was also the case that some staff would initially be unfamiliar with the needs of the people who used the service and the layout of the building.

Staff employed at the service had been through a thorough recruitment process before they started work. Checks were in place from the Disclosure and Barring Service (DBS) to establish if staff had any criminal record which would exclude them from working in this setting. References and DBS checks were confirmed before staff started work at the service and staff were asked to declare if their most recent DBS check was still accurate at each supervision session with the manager. The provider also checked that agency had received the appropriate training and had the correct DBS checks in place before they started work,

although the information for agency staff used most recently was not in the files supplied to us.

The manager took overall responsibility for matters related to medicines and we found medicines to be well organised and well managed. Staff had received the appropriate training before they administered medicines and their competence to administer medicines was reassessed every six months.

Procedures were in place for the safe booking in, storage, administration, stock control and disposal of medicines. We viewed records of the administration of medicines and found them to be accurate and complete. Stocks of seven medicines, including anti-coagulant medicines and controlled drugs, were checked and found to be accurately recorded and stocktaking records tallied with our count. Stocks of controlled drugs were checked daily by two staff.

There were protocols in place for PRN medicines, which are medicines taken as and when people require them and not consistently. These protocols contained clear information to inform staff how long each PRN medicine should be given before a GP was consulted. The required paperwork was in place to confirm that a GP had sanctioned the use of homely remedies such as cough syrup.

Requires Improvement

Is the service effective?

Our findings

Most staff had previous experience of working in care and knew the people who used the service well. They were able to tell us about people's day to day care needs. Staff received a very thorough and detailed induction when they started to work at the service, and some training was completed before staff began working shifts. We saw that staff, including kitchen and domestic staff, had received training in supporting people living with dementia and safeguarding people from harm. There was no structured induction for agency staff. The manager told us that information was passed to agency staff verbally. This meant that, given the reasonably high agency usage, we could not be assured that agency staff would have all the information they needed to meet people's needs promptly, especially at night.

Care staff had mentors who supported them through their induction and we saw that very specific areas of caring for people were covered. For example the induction included how to cut up people's food and how to be aware if people's dentures were not fitting correctly. The manager met with staff during their induction and both she and staff signed each section to document that staff were confident to deliver each particular aspect of care. Following their induction staff were supported with regular supervision sessions and an annual appraisal programme was in place.

Staff were supported to gain nationally recognised qualifications in care and received training in a variety of subjects to help them carry out their roles effectively. A rolling training programme was carried out which covered topics such as fire safety, infection control, dementia awareness, food hygiene, moving and handling and medication. Some staff had completed courses in caring for people with pressure ulcers and the service was part of the Prosper project which is designed to reduce falls and urinary tract infections by taking proactive measures to reduce risks. We noted that no staff had undertaken any training related to end of life care although the manager assured us this was planned. During our inspection the manager conducted a dementia awareness session which had been arranged prior to our inspection. The session was interactive and included lots of practical information to help staff support people living with this condition and understand the particular stresses and frustrations they feel.

The care staff had received training with relation to MCA and DoLS and showed a basic awareness of the principles of the MCA. Staff were aware that people's capacity to consent to care and treatment could fluctuate, particularly for those living with dementia. Care plans recognised this and we saw that care plans distinguished between people's lack of capacity to consent to have their medicines for example and their capacity to make everyday decisions such as what to wear or where they wanted to eat their meal. All staff had an MCA crib sheet, reminding them of the basic principles related to people's capacity to choose and consent.

We noted that there was a difference of opinion regarding one person's capacity to consent. Staff maintained that one person's decision to remain in bed a great deal of the time was their choice but district nursing staff and local authority staff with responsibility for safeguarding felt this demonstrated a lack of understanding about the person's condition and their ability to give informed consent. No formal capacity assessment or Best Interests meeting had taken place yet regarding this particular issue. Whilst it was

encouraging to see how the service promoted people's ability to make choices this difficult issue was set to be explored further to ensure that the person received the appropriate care and attention.

DoLS applications had been made for some people and the manager was waiting for decisions about to be made by the local authority. The service was on the outskirts of a village and in the middle of a large amount of land. People who used the service would have found it difficult to access the local village safely for these reasons and due to their being limited pathways to the village on the main road. We found that people therefore did not leave the service without staff support, if available, although the manager told us that one person had previously been risk assessed to walk to the village. Although this in itself did not constitute a deprivation of liberty it did mean there were some limitations to people's free movement which the manager assured us they would consider.

People who used the service were mostly positive about the food and people enjoyed their lunch in a relaxed and sociable atmosphere. One person summed this up saying, "The food is good and we get choices every day for breakfast, lunch and supper. They make tea and lots of drinks". Another person expressed the same opinion saying, "The food is lovely and there's always plenty of food". A relative also gave very positive feedback saying, "The food is freshly cooked every day and they get lots of choice".

Lunch in the dining room was a pleasant and sociable. We noted that staff brought some people through for lunch very early which meant they were sat in the dining room waiting for their meal for almost 40 minutes. Staff told us that this was not usual and stated that the chef was very new which may have been the reason for the delay. Drinks were regularly topped up and people were encouraged to sit wherever they wanted and be as independent as possible. There was a choice of meal and of drinks and those people who needed staff to assist them to eat their meal were supported sensitively. We observed one member of staff offering lots of choice to the person they were supporting, such as asking them which bit of the meal they would like to eat first. This aspect of good practice was also commented on by a staff member from the local authority safeguarding team who visited the service after our inspection.

The new chef had a list of people's particular dietary needs and we noted that high calorie snacks and additions to meals were available to help people maintain or gain weight. One person had been in the habit of missing meals before they came to the service and their care plan gave staff clear guidance about actively offering the person food so that they did not miss any meals.

People at risk of not eating or drinking enough had their food and fluid intakes recorded. Those charts we viewed were fully completed and fluid charts had a clear target amount and advice was sought if people failed to achieve this target consistently over a 24 hour period.

We found that where people had been found to have lost weight, appropriate healthcare professionals such as dieticians and speech and language therapists, had been involved. For example we saw that one person had been placed on a pureed diet and we observed staff providing this. However we noted that, contrary to the care plan, this person's weight was not being monitored and recorded weekly. We found this was also the case for another person who had not been weighed since the previous month. This meant that we could not be assured that staff were always able to note changes in people's weight quickly and take prompt action.

Records showed that people had access to a variety of healthcare services including GPs, district nurses, speech and language therapists, dieticians, opticians and occupational therapists. One relative told us, "When [my relative] arrived [their] legs were poorly but since being here they have improved tremendously, so they are looking after [them] well." We saw that the mental health and falls prevention teams had been

appropriately involved in people's care. We noted that one person had sustained a very great number of falls. Staff felt some of these falls had been as a result of the person deliberately placing themselves on the floor and had witnessed this. The person was referred to the specialist dementia support team and the manager was in the process of trying to secure additional one to one funding for the person to enable them to enjoy more activities. Their care plan contained information to guide staff to respond appropriately to this particular behaviour.

Although feedback from the local GP service was broadly positive and they felt that things had improved in recent times, they did highlight some concerns. They felt that on occasion the staff did not call them out promptly enough in response to a person's deteriorating condition but their main issue related to the accuracy of information given to them when they visited. Staff were not always clear exactly why the GP had been called and could not supply all the information they required. This was predominantly seen as a matter of poor communication systems and had the potential to cause delay and frustration. The GP praised some senior members of staff who they found to be very competent and whose information could be relied upon. The manager was not always felt to have the most accurate information about people's conditions.

The issue of poor communication systems had been further complicated by a serious breakdown in the relationship with the district nursing team which visited the service. Communication between the district nursing team and the service was poor and the system designed to ensure clear communication of information was not working effectively. The impact of this breakdown for people who used the service was significant and we were concerned that not enough was being done to improve matters. The very poor relationship and lack of professional respect and courtesy on both sides had already had a potential impact on one person who had failed to receive the treatment they urgently required which had resulted in a serious deterioration in their condition.

Good

Is the service caring?

Our findings

All the people and relatives we spoke with commented positively about how kind and caring the staff were. They told us they were kind, respectful and discrete. One person who used the service said, "The staff help me the best they can and I would tell them if I wasn't happy. They spend time with us, talking, even though they are very busy." Another person said, "Staff are kind and caring and they treat me with respect and dignity" A third person commented, "Staff are very kind and they help me a lot. They often talk to me as they pass my door. Yes, they treat me with respect and they are very caring."

We witnessed some very caring interactions between staff and the people they were supporting and it was clear that relationships were easy and staff knew people well. We witnessed a member of staff supporting a person to eat their meal. They showed kindness and encouraged the person to eat and do as much for themselves as they could. Their language was supportive and friendly as they encouraged the person to eat, saying, "Go on, you can do it. Try a little bit more".

People told us that staff responded kindly if they were distressed or in pain and those who were able to operate them had call bells within reach. Where people had been identified as being unable to summon staff if they needed help we saw that they were checked regularly to see if they needed anything. One person was keen to tell us how much care staff took when they used the hoist. They said, "They take care with the hoist machine – especially [named carer] who's wonderful!" Another person was keen to point out how the service managed their pain and we noted that their care plan contained information to guide staff about how to care and support for this person and minimise their pain.

People were involved in making decisions about their care. People were able to choose when to get up and go to bed for example. Care plans were personalised and documented people's preferences about the way they wished to be cared for and supported. There was evidence that most plans were reviewed with the people they concerned or their relatives if appropriate. One relative told us, "I am invited to my [relative's] care reviews and they do listen to us as a family". Another relative said, "We get sent forms to fill in and we are invited to family meetings and reviews and I think everyone works hard here. We are very happy with everything".

People told us they were given the opportunity to give their views about the care they receive. Resident meetings were held, but not regularly. A recent relative's survey had received a very positive response. We saw that where issues had been raised in the survey, actions had been taken. For example there was an issue with the storage of large quantities of incontinence pads in people's rooms and the service had now moved these to an outside storage area. A joint resident and relatives meetings had been held in February. We saw that a wide variety of issues had been discussed and the meeting had provided an opportunity for an exchange of views.

The service had procedures in place relating to support and care for people at the end of their life. However staff had not yet received end of life training although this was planned. Staff demonstrated an awareness of people's particular needs as they approach the end of their life and we saw staff supporting people with

great sensitivity.

Good

Is the service responsive?

Our findings

People's needs had been assessed before they moved into the service to establish if the service was suitable for them. Once people started to use the service their assessed needs were drawn up into a care plan. Care plans set out people's choices and preferences and built up a picture of how each person wished to receive their care. We found that people's particular likes, dislikes and preferred routines were well documented in their care plans and that these were reviewed appropriately. One person told us, "I get up when I want and I go to bed when I want. We have activities in the week with singers and bingo".

We saw that plans contained information about how people liked to receive their care, including personal care, and about the things that were important to them. We found that staff knew this information well and acted in accordance with it. We noted that one person's plan documented how they liked to watch wildlife but that their bed was turned away from the window so they could not see out. We asked staff about this and they were well aware of this person's fondness for birdwatching and told us that staff had offered to move the bed but the person did not want this. We spoke to the person and they confirmed this. This showed to us that this person's care plan was an evolving document which reflected needs and wishes as they changed and that people's wishes were respected.

People who used the service were supported and encouraged to follow their own interests and hobbies. The service provided a range of activities and occupation for people and had a specific member of staff in place to organise activities each day, including weekends. Recent activities included story reading, film afternoons, parachute games, board games, knitting and chair exercises. Forthcoming activities were advertised on a noticeboard and used pictures as an additional communication aid. One relative commented, "They have lots of activities to do in the week and I have no concerns about my [relative]".

Each person was assessed as high, medium or low depending on whether they regularly joined in with structured activities, whether they spent a lot of time in their rooms and whether they had regular visitors. This identified people most at risk of social isolation and these people were a priority.

We saw that one person, who was mainly nursed in bed, had a record of various activities including pet therapy and reading. This person had received one to one sessions at least four times a month as well as being invited to take part in communal activities. One to one sessions were provided for all the people who chose to remain in their rooms. Trips out were also organised once a month and people really valued these. People's cultural needs were documented and one person's relative was positive about the fact that a local priest visits regularly saying, "[My relative] loves [their] church".

There was a complaints policy and procedure in place and this was clearly displayed. People told us they knew how to make a complaint if they needed to. One person who used the service told us, "If I had any worries I would tell my daughter but I have no complaints at all here". Another commented, "I have no complaints about the staff. They all work hard". No formal complaints had been logged and only one informal concern had been raised and dealt with to the complainant's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People who used the service, and their relatives, were positive about the open culture at the service and about the manager. One person who used the service said, "I am happy with everything and the home is well run I think, and the manager does talk to me and the others" A relative explained, "Rubby [the manager] is realistic. [My relative] has been here a long time and I am confident they are doing their best here". Another relative was keen to point out how homely and welcoming the service was over the Christmas period. While a third commented, "We can visit when we want and staff look after people well. It's a nice atmosphere".

Staff told us they felt well supported by the manager and found her approachable. We saw that staff meetings were not frequent and were not always well attended and the manager indicated that some staff were not always willing to attend. We also noted that there was a consistent pattern of staff sickness which the manager found difficult to address and was tackling through the disciplinary procedure. These issues within the staff team made it more difficult for the manager to ensure consistent care was provided. A staff survey was being prepared which was designed to identify any particular issues staff had.

Although supported by the project manager, the registered manager had not had a deputy in place for well over a year. A recently appointed deputy had not proved suitable and had left quickly. The provider had not been proactive in filling the vacancy in order to establish a stable management team to address some of the difficult issues which were facing the service. Although steps had been taken to appeal to prospective care staff to fill any vacant posts, such as an increase in the basic wage and enhancements when nationally recognised qualifications are achieved, less thought seems to have been given regarding support for the registered manager. Given the particularly difficult relationship that had evolved between the service and the local district nursing team, support for the manager required a higher priority.

The issue documented earlier in this report regarding the breakdown of the relationship between the service and the district nursing team had not been resolved over time and was deteriorating. This was a very serious issue and the provider had not been proactive in supporting their registered manager to improve the situation. We were also concerned that there was no rostered on call system in place, resulting in the manager being permanently on call. The manager lacked the confidence to delegate tasks such as supervising staff and had taken back a lot of responsibility for these tasks herself to ensure they were done correctly. This put the manager under additional pressure.

The manager attended a local forum for independent managers which provided them with updates on health and care related matters and they had signed the service up to be part of the Prosper project to promote hydration to reduce falls, pressure sores and urinary tract infections. This had not had a positive impact yet on the numbers of these incidents.

There were systems in place to monitor the training and supervision of staff. A training matrix identified when staff had completed training or required a refresher and we saw that plans had been made for additional training.

An audit system was in place to assess and monitor the quality of the service provided. Audits and spot checks for cleaning, laundry, kitchen, infection control and medication and were carried out by the manager and the project manager and action promptly taken where issues were highlighted. The medication audit identified five residents each month and looked at their medication in depth, highlighting even small issues if necessary. Each audit was given a percentage score so that progress was clear from one month to the next. A new medication audit, which had been developed by the local Clinical Commissioning Group, was about to be trialled at the service to see if this was more effective than their current format.

Health and safety and maintenance checks, such as those for water temperatures, hoists and slings, call bell systems and window restrictors, were carried out monthly. The service also inspected profiling beds and wheelchairs, including those privately owned, each month to make sure they were safe to use. These records were very clear and well organised. The project manager had been employed to oversee the future development of the service and to implement some improvements to the recording and auditing systems. Although this was a work in progress and the service was moving over to electronic recording, we could see that the changes had already had a beneficial effect.

We noted that an audit of the dining experience had been carried out and had identified some specific issues which had then been attended to. We saw that the audit had found that a member of agency staff had supported someone to eat their meal while standing over them. This was reported back to their agency.

The registered manager understood their responsibilities and had sent all of the statutory notifications that are required to be submitted to us for any incidents or changes that affect the service. They also involved other agencies, such as the local authority safeguarding team, appropriately and worked in partnership with them.