Broome End Ltd

Broome End

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 17 and 19 October 2018 and was unannounced.

Broome End is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates 37 people, some of whom are living with dementia, in one adapted building. At the time of our inspection there were 27 people using the service.

Following our last inspection on 12 July 2017 the service was given a final rating of 'Requires Improvement'. A breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified because the provider failed to have effective systems in place to ensure people's medicines were stored and managed safely. Improvements were also needed in relation staffing levels, due to high reliance on agency resulting in people not being supported by staff that understood their needs and a lack of cohesion amongst staff. Limitations on staff time had meant that the care provided was largely task focussed, with little meaningful stimulation or interaction. We also identified that the governance and quality assurance systems were not effective and had not identified failings in the service, found at the inspection.

At this inspection we found significant improvements had been made. A new manager was in post and had registered with the Care Quality Commission (CQC) to manage the service. A registered manager like registered providers, 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.

Systems had been implemented which were used to continuously assess and monitor the quality of the service. The registered manager and staff had a clear understanding of what was needed to ensure the service continued to develop, and ensure people received high-quality care.

There were sufficient numbers of staff available to meet people's needs. Recruitment remained an issue for the service largely due to the rural location. However, three new care staff had been recruited, and a small pool of bank and regular agency staff were being used, to provide continuity. Since our last inspection a deputy manager had been recruited. Where previously the registered manager had been overseeing all aspects of the service, the additional resources had freed up their time to focus more on their managerial duties.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019. However, for this inspection we found oral health training for staff was basic. The deputy manager had taken

on the role of oral health champion and outlined plans to improve oral health care, including training. Champions are staff that have shown a specific interest in specific areas. They are essential in developing best practice, by sharing their leaning and acting as role models for other staff.

Staff felt supported by the management team, in particular the registered manager. Staff were encouraged to further their knowledge and skills through a combination of training methods, including eLearning as well as external trainers coming to the service. Staff's competencies had been assessed to ensure they had understood what they had learnt and were able to effectively apply it to their daily practice.

People were protected from risk of harm and staff had a good understanding of processes to keep people safe and how to report concerns. Safeguarding incidents were managed well. Peoples' medicines were being managed safely. A thorough recruitment and selection process was in place, which ensured staff recruited had the right skills and experience, and were suitable to work with people who used the service. The deputy manager had engaged with the local authority Prosper scheme. This scheme is aimed at promoting new ways of reducing preventable harm from falls, urinary tract infections and pressure ulcers. The implementation of the Prosper programme, combined with the use of assisted technology, such as sensor matts, had clearly had an impact on reducing the number of falls, in the service.

Our previous inspection found, people's meal time experience varied according to which staff member was assisting them. At this inspection, whilst we found improvements had been made, there were isolated incidents where staff interaction was lacking, but the remainder of the meal time was seen to be a positive, and sociable experience. People were supported to eat and drink enough to maintain a balanced diet. People were supported to live healthier lives and had good access to healthcare services, where required.

Although, improvements to the premises had been made, through a programme of redecoration, further consideration in conjunction with good practice guidance was needed in relation to the suitability of the layout and living space in the dementia unit.

People, their relatives, friends and health professionals were complimentary about the attitude and capability of the staff, the registered manager and the care provided. The community matron, district nurse and a student nurse visiting the service during our inspection all commented that they had seen a great improvement in the service since the new manager came on board. Staff had developed good relationships with people using the service. Staff treated people with kindness, promoted their independence and respected their privacy and dignity.

People were supported to express their views and be actively involved in making decisions about their care. Consent to care and treatment was being managed and sought in line with legislation and guidance.

The provider was meeting the requirements of the Accessible Information Standards. This set of standards sets out the specific, approach for providers of health and social care to identify, record, share and meet the communication needs of people with a disability, impairment or sensory loss. People had access to a range of activities, depending on their interests, within the home and via external sources, and chose if they wanted to take part. Posters were displayed around the service advertising events and asking people for their suggestions and ideas. People were supported to follow their chosen faith and religious practices.

Systems were in place to ensure people's concerns and complaints were listened and responded to. Records showed complaints had been investigated in full and an apology provided to the complainant. Complaints had been used to improve the quality of the service. No one currently using the service was receiving end of their life care, however feedback from people's relatives in thank you cards and discussions

with staff confirmed people were supported to have a comfortable, dignified and pain-free death.

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

People were protected from risk of harm and staff had a good understanding of processes to keep people safe and how to report concerns.

Staff understood risks to people, and measures were in place to keep people safe, in the least restrictive way. Safety concerns and incidents were managed well and used to improve the service.

There were sufficient numbers of staff available to meet people's needs. Systems for recruiting new staff were carried out safely to ensure potential employees were suitable to work at the service.

People's medicines were managed consistently and safely.

Systems were in place to protect people and staff from infections. Staff understood their roles and responsibilities for keeping the premises clean and hygienic.

Is the service effective?

Good

Staff had access to a range of face to face and computer based training which gave them skills and knowledge to carry out their roles. Systems were in place to assess staff's competency following training to ensure they understood what they had learnt and were able to effectively apply it to their daily practice.

People were supported to eat and drink enough to maintain a balanced diet. People were supported to live healthier lives, received ongoing healthcare and had good access to healthcare professionals, where required.

Although improvements to the décor in the premises had been made, further consideration is needed in relation to the suitability of the layout and space in the dementia unit.

Consent to care and treatment was managed and sought in line with legislation and current guidance.

Is the service caring?

Good

People were treated with kindness, and respect by staff. Staff showed concern for people's well-being in a caring way and responded to their needs quickly.

People were supported to express their views and be actively involved in making decisions about their care, and treatment, where required.

People's privacy, dignity and independence respected and promoted.

Is the service responsive?

Good

People received personalised care that was responsive to their needs.

Systems were in place to ensure people's concerns and complaints were listened and responded to.

Processes were in place to ensure people were supported to have a comfortable, dignified and pain-free death.

Is the service well-led?

Good

The registered manager and staff had a clear understanding of what was needed to continue to develop the service. They demonstrated a shared responsibility for improving the service and promoting people's wellbeing, safety and security.

Systems were in place to ensure performance, risks and regulatory requirements are understood and managed.

People who use the service, their relatives and staff were involved in making decisions about the service.

People, their relatives and staff spoke positively about the registered manager. Staff felt supported by the registered manager.

Improvements made by the registered manager demonstrates there has been a willingness to work in partnership with other agencies to improve the service.

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 17 and 19 October 2018 and was unannounced. On the first day of the inspection the team consisted of two inspectors and a dental inspector who looked in detail at how well the service supported people with their oral health. The second day of the inspection was completed by one inspector.

Before the inspection we reviewed information available to us about this service. This included information shared with us by the local authority, Quality Improvement Team (QIT) and West Essex Clinical Commissioning Group. The registered provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We also reviewed previous inspection reports and the details of complaints, safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury.

We spoke with five people who were able to express their views, but not everyone chose to or were able to communicate with us. Therefore, we used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two relatives and a friend of a person using the service. We spoke with one care staff, an activities co-ordinator, the cook, deputy manager, registered manager and the provider. We also spoke with the community matron, a district nurse and a student nurse visiting on the first day of the inspection.

We looked at three people's care records, recruitment records for three staff and reviewed records relating to the management of medicines. We also looked at records in relation to complaints, staff training, feedback in peoples, relatives and staff surveys, maintenance of the premises and equipment and how the

registered persons monitored the quality of the service.

Good

Is the service safe?

Our findings

At our last inspection on 12 July 2017 we found systems for administering, storing and recording medicines needed to improve. West Essex Clinical Commissioning Group (CCG) also shared concerns with us around medicines management following their pharmacist inspection on 17 July 2018. The CCG have since shared that a follow up visit in October 2018 found that improvements had been made. This was confirmed at this inspection where we found medicines were being managed safely. Random sampling of people's medicines, against their records confirmed they were receiving their medicines as prescribed by their GP. Medication Administration Record (MAR) charts provided staff with clear information about people's medicines and how they liked to be supported to take them. The PIR stated and records confirmed that only trained staff administered people's medicines. Staffs competency to manage medicines was also regularly assessed. MAR charts were being checked daily at the end of every medication round, and if anomalies were identified a supervision was carried out with the member of staff responsible, to prevent further errors occurring. Medicine audits were being carried out monthly to check accurate records were being kept and that medicines were being stored and disposed of correctly.

People told us they felt Broome End was a safe and secure place to live. This was confirmed in discussion with people visiting the service during the inspection, for example, one relative commented, "I feel my [Person] is safe here, the staff are very kind." Posters were clearly displayed on notice boards about how to raise a safeguarding concern. These provided clear guidance to people, visitors and staff on how to report concerns within and outside the organisation. Staff told us they had received updated safeguarding training and were aware of different forms of abuse and their responsibility to report concerns, record safety incidents and near misses. They demonstrated a good awareness of procedures to follow and knew who to inform if they witnessed or had an allegation of abuse reported to them.

Staff told us they had received training to understand causes of anxiety and distress and how to support people at times when their behaviours could be challenging to others. For example, one member of staff told us, "If people are anxious, it's because they might need support, such as needing to go to the toilet. If this fails, then I will sit with them, hold their hand, but if this makes the situation worse, I will leave them for a few minutes to see if they calm down, and then go back, or get another member of staff to intervene. It's about communication, and getting to know the person."

Our previous inspection identified risks to people using the service were not always well managed. At this inspection we found improvements had been made when anticipating and managing risks. A substantial amount of work around falls prevention had been undertaken by the deputy manager. They had developed a 'flow chart' which acted as a quick 'at a glance' guide for staff to assess new people moving into the home, or help to identify possible factors as to why a person may have fallen. Additionally, we saw a range of assistive technology, such as chair sensors, motion sensors and sensor mats that alert staff when people are moving had been used to reduce the risk of falls. Discussion with the deputy and a review of incidents and accident records reflected that the implementation of the Prosper programme, combined with the use of technology had clearly had an impact on reducing the number of falls, in the service.

A daily 'team leader check list' had been implemented. This was used twice daily to assess the safety and wellbeing of people using the service, equipment, medicines and the environment and provided a current picture of safety in the service. A business contingency plan was in place detailing who to contact in an emergency such as a lift breakdown, gas supply failure or if residents needed to be evacuated where they would be relocated to. Staff knew who to contact if such an emergency arose. Each person had a Personal Emergency Evacuation Plan (PEEP) in place providing guidance to staff on how to support them to evacuate the building safely in the event of an emergency. These were colour coded, red, amber and green to reflect the level of assistance required, for example, people with a green rating were able to move independently, whilst a person rated red would need assistance of two staff and equipment. Weekly fire safety checks were being carried out by the maintenance person and outside contractors. Maintenance records showed fire alarms were regularly checked to ensure they were in good working order and the gas safety certificate was up to date. Records showed that the hoisting equipment was regularly serviced and personal electrical appliance (PAT) testing had been carried out to ensure that electrical equipment was in safe working order.

People and their relatives confirmed there were sufficient numbers of staff available. People's comments included, "Yes, I think there is enough staff," and "There are always staff about." One relative commented, "There is always enough staff." Another told us, "Staffing is not a problem." Our previous inspection identified, there was a reliance on agency staff to fill vacant posts, who did not know the needs of people using the service, which impacted on continuity of care and staff cohesion. The registered manager told us there had been an emphasis on recruitment, but due to the rural location and having two other care homes nearby, recruitment was difficult. However, they told us they had recently offered three new care staff posts, subject to recruitment checks. A small pool of bank and agency staff were being used, however the same agency staff were used to provide continuity. We saw their photographs had been added to the staff board, so that people and visitors knew them, by name.

The service had a process for safe recruitment and records confirmed appropriate checks had taken place. These included, a completed an application form, proof of identity, satisfactory references and a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

The premises were clean and tidy. We saw signs around the premises reminding staff to wash their hands and observed staff following these appropriately. Staff confirmed they had received infection control training and had access to infection prevention and control policies and expected best practice guidance. We observed staff using personal protective equipment at all times when this was needed. Cleaning schedules were in place and followed by housekeeping staff. Cleaning products were stored safely, and colour coded equipment, such as mops, were being used appropriately to ensure the risk of cross infection was minimised. People had been provided with their own personal slings where they needed assistance to mobilise to avoid the spread of infection.

Good

Is the service effective?

Our findings

Our previous inspection found most staff training was completed via computer based learning, known as eLearning. There had been no evidence that staff's competencies had been assessed to ensure they had understood what they had learnt and were able to effectively apply it to their daily practice. At this inspection the registered manager provided a training matrix setting out all mandatory and additional training staff had completed including National Vocational Qualification's (NVQ). They told us, staff were encouraged to further their knowledge and skills through a combination of training methods, including eLearning as well as external trainers coming to the service. Staff confirmed and records showed training provided was a mixture of eLearning and face to face classroom based sessions. For example, the district nurse had provided a practical demonstration and discussion about skin care and inhaler techniques. A pharmacist had visited the service and provided medication training. Additionally, moving and handling practical training had been booked for 02 November 2018. The registered manager told us they were also in the process of arranging practical first aid training.

Staff told us the training they received had provided them with the knowledge and skills to meet people's specific needs. Training included, but was not limited to, Dementia, Parkinson's, wound care, stoma care, caring for people with respiratory problems and Non- Abusive Psychological & Physical Intervention (NAPPI). However, we identified that oral health training for staff was basic and further training would increase their awareness. The deputy manager had taken on the role of oral health champion and outlined plans to improve oral health care, including training. The registered manager told us staff competencies were assessed via 'on the spot' training and through regular supervisions. They told us where they observed poor practice, they gathered staff for an impromptu training session, to establish what went wrong, and why this should not happen. These practical supervisions focussed on safe practice and were recorded as part of staff's ongoing development.

When new staff joined the service, they told us they received an induction. Staff files showed they had completed or were in the process of completing a comprehensive induction consisting of a range of training, including the Care Certificate. The Care Certificate was developed jointly by the Skills for Care, Health Education England and Skills for Health. It applies across health and social care and sets a minimum standard that should be covered as part of induction training of new care workers. One member of staff told us, "All new staff have to compete the Care Certificate. They are shadowed for two months by an experienced member of staff, and if they do not feel confident at the end of the two months, additional training is provided."

At our previous inspection we found, people's meal time experience varied according to which staff member was assisting them. At this inspection, whilst we found improvements had been made, there were occasions where staff interaction was lacking. For example, one member of staff stood behind a person dragging them back in their seat and lifting them under their arms to sit them further back in their chair, without any engagement. Another member of staff woke a person asleep at the table to offer them their meal, but for the remainder of the mealtime there was no further interaction with this person. However, these were isolated incidents, and the remainder of the meal time was seen to be a positive, and sociable experience for people

with a good ratio of staff present to ensure they received the support they needed to eat their meal. Staff were supportive, making lots of eye contact with people and encouraging them to eat. People confirmed they could choose what they wanted to eat. Staff were observed showing people a choice of food using pictorial menus and general discussions about the meals.

People told us, and we saw for ourselves that the food was good and there was plenty of it, lots of drinks were offered and that they were encouraged to drink. One person told us, "The food is nice, actually really good, I can't grumble." Other comments included, "I like the food," and "The food is always lovely, very nice," and, "They do a lovely Sunday roast." We spoke with one person and their relative about the food. The relative told us, "My [Person] always gets enough to eat, they are on supplements as well, as they have a poor appetite, but staff encourage them to eat by giving them their favourites. They had egg on toast for breakfast this morning. The person told us, "Breakfast was really nice." The cook, had good knowledge of people's needs, and was clear about their specific dietary needs, including their likes and dislikes. They told us, "If people don't like what is on offer, I will prepare or cook an alternative."

Staff were aware of people's dietary needs, for example one member of staff told us, "We have one person who has facial paralysis and they can't have solid food as they are at risk of choking, we have to make sure the consistency of the food is right, using thickening agents, to help making swallowing easier for them." Where people were at risk of malnutrition and dehydration, or had specific dietary needs these were documented in nutritional care plans. People at risk of malnutrition were weighed weekly and where significant weight loss was identified because of poor health, they had been referred to the dietician for advice. The chef, had good knowledge of people's specific dietary needs, including what food groups, were needed to provide additional calories for those at risk due to weight loss. 'Booster Boxes', containing high calorie snacks were provided to the people throughout the day and night where they were identified at risk of malnutrition. Additionally, a member of staff was allocated daily as a 'fluid boost champion', to check and encourage people to drink fluids, to ensure they remained hydrated.

People told us and records confirmed they had access to a range of healthcare services, such as the dietician, SALT, district nurses, mental health team, occupational therapy and physiotherapy services. The registered manager told us, the GP conducted a weekly round at the service with the community matron where all aspects of people's health and wellbeing were discussed. The community matron, district nurse and a student nurse were visiting the service during our inspection. They all commented that they had seen a great improvement in the home since the new manager came on board. The district nurse, told us, "Things have definitely improved here over the last year, I have no concerns."

Broome End accommodation is spread across three floors with a range of communal lounges and dining areas for people and their relatives to use. Our last inspection raised concern that the 'dementia unit' named Dove (located on the top floor) was not designed to meet people's needs. At this inspection, although we saw improvements had been made to Dove unit, such as painting the hand rails leading to bathrooms, door frames to toilets and bathrooms yellow to make them more distinguishable, further consideration was needed in relation to the suitability of the layout and living space in the dementia unit. Dementia friendly signage was being purchased, to be fixed to doors and walls to help people find their way around. A programme of redecoration had also taken place throughout the service to ensure the premises was safe and a comfortable place for people to live. People and their relatives told us their opinions on the refurbishment had been sought and taken into consideration. One person told us, "I have a lovely room and this is my home." The service has an extensive garden area which people can access if they choose. One person, told us and we saw that they helped with the gardening, and was involved in developing a roof top garden.

The Mental Capacity Act (MCA) 2005 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. We looked at how the MCA was applied and managed in the service. Management and staff understood their responsibilities to ensure people were given choices about how they wished to live their lives. Where decisions were being made on people's behalf their family representatives and/or professionals were involved in making decisions that were in the best interests of the person. For example, where a person's medication was being administered covertly (disguised in food and drink) records showed this was been done in line with MCA requirements and a multi-disciplinary team had been involved in making a 'best interest decision' to agree to the person's medicines being given in this way.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager confirmed appropriate applications had been made to the local authority for people subjected to restrictions to their freedom for their own safety. Staff had a good understanding of DoLS legislation and demonstrated how these were put into practice. One member of told us, "[Person] has a DoLS in place because they have a lap belt fastened when in their reclining chair, restricting their movement. This prevents them from falling out of the chair. They told us, because the person lacked capacity to make this decision a meeting had been held, with relevant people including a social worker to agree that it was in their best interests and the DoLS request had been authorised.

Good

Is the service caring?

Our findings

At our previous inspection, people and their relatives expressed concern about the services reliance of agency staff and the impact that this had on the care that people received. At this inspection people, their relatives, friends and health professionals were complimentary about the attitude and capability of the staff and the care provided. One person told us, "I am happy with the home, the staff are very caring and kind." Another person commented, "I'm happy here staff are very kind. If I need anything I can always ask the staff to help me." Other comments included, "I am happy here and the staff are lovely and kind," and "The staff are good because they really do care." The community matron told us, the registered manager and staff had worked hard to improve the service, and when they now visited they saw regular staff and less agency. They told us, "The carers do seem to really care, they do a really good job, they are very good at picking up things and responding to concerns in relation to people's health."

People received the care and support they needed from staff who knew and understood their needs well. For example, discussion with one member of staff showed they clearly understood how to support people to manage periods of anxiety and distress. They provided several examples, including what they did to support a person who became distressed and wanted to leave the building. For example, they told us, "[Person] lacks capacity and is at risk if they leave the service alone, but rather than restrict them from leaving I went with them. People need to get out sometimes, all they wanted to do was walk outside to see the horses, it's about knowing people and what works." We also observed people being treated in a dignified way. For example, where a person was anxious about taking their medicines, staff spent time showing the person their medication, their MAR chart and explaining what it was and why they needed it. This process gave the person reassurance that they had taken their medicines and reduced their level of anxiety.

The interactions between staff and people using the service were friendly and staff showed concern for their wellbeing. We overheard nice conversations between people and staff, for example, a member of staff was heard speaking to a person, "Hi [Person] you look smart today, have you had your hair cut." The person responded, "Yes, and thank you." We also observed a member of staff supporting a person to transfer from an arm chair to their wheelchair. They were patient and kind, commenting, "Push yourself up [Person], well done." They guided the person into the chair and asked, "Are you comfortable, are you sure? I like that pink colour on you, I know I've said it before but that colour really suits you."

People's care records reflected what they could do for themselves and how staff should encourage this to promote and maintain their independence. We saw that staff provided encouragement to people when they needed it and supported them to retain their independence wherever possible. People able to walk with the use of aids were monitored to ensure they were safe, when mobilising. Plate guards, brightly coloured plates, adapted cutlery and light weight cups were provided to enable people to continue to feed and themselves.

People told us they could make choices and decided how they spent their day. One person told us, "I get up when I am ready and don't like to come downstairs too early. Another person told us, "I'm very happy here, this is my home, I have a lovely room and get up when I want to." One member of staff told us, "[Person]

liked to access the community to go shopping and visit friends. They have a history of falls, but we do not stop them going out. Measures have been put in place to maintain their independence, for example, they have a card with the address and telephone number of Broome End. They also have a mobile phone, and they have given their relative permission to track their movements."

The service had taken steps to ensure people's communication needs had been identified and how these were to be met. Peoples care plans contained detailed information about how they communicated. For example, one person's care records reflected they were profoundly deaf and used a white board and pen to communicate. The care plan included detailed guidance for staff on how to use the whiteboard to communicate, including using clear and simple language to allow the person to read what had been written and respond. Staff knew people's communication needs well, for example one member of staff told us, [Person] used to teach languages, but due to their dementia they have reverted to their native language, so to communicate with them we use flash cards, with pictures. I can also speak a little bit of their language, which helps."

People were supported to express their views and be involved in making decisions about their care. Regular resident meetings were held to find out their thoughts and opinions about the service, including their care and the support they received. We saw one person reading the minutes of the most recent residents meeting. They told us they had attended and had, "Sorted out quite a few things." People's care plans clearly documented how decisions about their care were made. The registered manager told us they were currently reviewing care plans and had involved people's next of kin to ensure information was up to date in relation to their care needs, their past, their preferences, and the people who important to them. Where people lacked capacity to make certain decisions about their care, such as needing support with eating, drinking, their personal care and taking their medicines appropriate MCA assessments had been completed. These agreed it was in the person's best interests to receive support from staff to take their medicines safely, ensure they were clean and had adequate food and fluids to stay healthy.

Best interest decisions were being made with the involvement of people's next of kin, and relevant professionals. Where consent to treatment forms had been signed by family members; information had been obtained to ensure the family member was the persons Lasting Power of Attorney (LPA). A LPA is a person that has been appointed by the person to help them make decisions or to make decisions on their behalf, in relation to health and welfare and finances.

People's privacy, dignity and independence was respected. Staff understood it is a person's human right to be treated with respect and dignity and to be able to express their views. We observed them putting this into practice during the inspection. Staff respected people's decision to spend time on their own in their rooms. Staff were observed gaining people's consent to enter their rooms and provide personal care. Staff knocked on people's doors whether or not they were open or closed, rather than just walking in. We saw people were clean, dressed in appropriate clothing, their nails were clean, hair was tidy and their glasses were clean. People with hearing impairments and who used hearing aids, were supported to ensure these fitted properly and the batteries were working.

Good

Is the service responsive?

Our findings

Our previous inspection identified that people did not always receive care suited to their individual needs and preferences. This was because care plans had lacked information and guidance for staff about how people's care was to be delivered and how potential risks to their safety were to be managed. At this inspection we found improvements had been made to the care plans. A review of care records found these contained all the relevant information staff needed to provide people's care, including managing risks, their likes, dislikes and abilities. Furthermore, the care plans ensured people had their rights, wishes and needs upheld. However, we found information was quite basic in certain areas, such as oral health. Where people had declined mouth care staff had not always recorded this, but we saw staff had been quick to identify and arrange dental care for a person with a swollen cheek and experiencing pain. The registered manager told us they were in the process of reviewing all care plans, and archiving old information. At the time of the inspection they had reviewed 12 with one in progress, which accounted for the lack of detail in some care records.

The provider used an electronic care planning system. Staff recorded information about people's health and the care provided on a touch screen. This linked directly to the persons care plan, and provided a real-time record of the care provided. The system enabled instant changes to be made to care plans, when people's needs changed, so that staff were always working to the most up to date information. People's care records contained information showing they or their family members were involved in discussing and reviewing their care.

People told us they received personalised care that was responsive to their needs. This was confirmed in discussion with relatives, friends and professionals visiting during the inspection. For example, one relative told us, "This home is small and its very friendly, staff know my [Person] well and I am kept informed about their health. Before they moved in they had lost weight, the staff are monitoring their weight, and they are stable at present. They [staff and cook] know what they like to eat, and makes sure they have snacks." Another relative told us, "Staff look after [Person] very well. They [staff] are very good on the medical side of things, they always air on the side of caution, if they think they are not right they contact the GP, or take them to hospital. For example, [Person] fell and was taken to hospital, staff were concerned they had a chest infection, fortunately tests confirmed nothing was wrong. Staff are good they keep my [family member] informed, so that I don't panic and rush here."

The registered manager told us a new activities person had been recruited. People told us they were asked how they wanted to spend their time and for their opinion on what activities they wanted to take part in. One person told us, "I mentioned that I like gardening and they helped me to do this." The minutes of resident's meetings showed they were consulted on activities, and asked for their feedback to plan future events. A newsletter showed people had access to arrange of events they could choose from depending on their interests. These included, but were not limited to, chair exercises, a harvest festival and choir, music therapy, a variety of entertainers, arts and crafts, and pet therapy. Ten people had attended Bishop Stortford football club, along with people from other care homes for an afternoon tea and songs. A coffee afternoon had been held in aid of McMillian Cancer Research, attended by people and their relatives. Posters were

displayed around the service advertising events and asking people for their suggestions and ideas. The registered manager told us to ensure people could follow their chosen faith and religious practices, they were in the process of reintroducing regular visits from church groups and ministers of different faiths.

Systems were in place to ensure people's concerns and complaints were listened to and responded to. Information about how to make a complaint or raise a concern was pinned to notice boards throughout the service and in the main entrance hall way. The registered manager also told us they held twice yearly meetings with relatives, and that concerns could be raised at any time. The complaints file showed three complaints had been made since our previous inspection in July 2017. Records showed these had been investigated in full by the registered manager in a timely way and letters outlining the outcome of their investigation and an apology provided to the complainant. These concerns had been used to improve the quality of care provided. For example, concerns raised about poor standards of care had been investigated and found to be true. The registered manager took immediate action to redress the issues with staff, through supervision reminding them of the standards of care expected. They implemented twice daily checks and carried out spot checks, including unannounced visits over the weekends to monitor staff were providing the right level of care and ensure the premises was being kept clean. We saw a card form the relative in response, acknowledging the actions taken and thanking the registered manager for taking their concerns seriously and acting on them.

We saw 14 thank you cards from relatives of people on the notice board. All cards provided positive feedback about the service. An extract from one card, thanked staff for, "Helping my [Person] to settle in, be happy safe and cared for, you do an amazing job and my gratitude cannot be measured. It means the world to me to see them thrive."

At the time of our inspection, no one using the service was nearing the end of their life, and therefore we were unable to assess how this aspect of the service was managed. However, staff understood the importance of supporting people to have a good end of life. One member of staff told us, "It's really important to ensure people, at the end of their life are comfortable. I sit with them and hold their hand, to let them know I am here for them." A person visiting the service spoke of their gratitude to the provider, registered manager and staff for the care and support provided to their relative, that had lived and passed away at the service. They told us, "The staff were always kind to [Person] when they were here, especially at the end of their life, the staff looked after them and me. They are a lovely lot here, and I really appreciate all their support. A lot of staff came to my [Person] funeral, even those off duty. I wrote a eulogy, and gave a copy to the home thanking them for the kindness, care and support they showed, not only to my [Person] but extended to me. Broome End is not so much a care home, but more like a family to me. The registered manager is very kind and determined to provide a good service. They made the process of my [Person] dying a thousand times better."

Advance care plans were in place which gave people and their family the opportunity to express any wishes for the persons end of life care and funeral arrangements. These were in date and had been discussed with their family members, if appropriate. For example, one persons preferred priorities of care plan reflected they wanted to remain at Broome End, receive the last sacrament, and end their life without fear and to be free of pain. As part of people's end of life planning where it had been agreed people had a Do Not Attempt Resuscitation (DNAR) orders in place. A DNAR form is a document issued and signed by a doctor or medical professional authorised to do so, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR).

Good

Is the service well-led?

Our findings

Our last inspection identified that systems to monitor the quality and safety of the service were not used effectively by the management team and had not identified failings in the service. At this inspection we found the required improvements had been made. Systems were in place which continuously assessed and monitored the quality of the service. For example, the registered manager provided evidence that they carried out regular audits of the service, these included but were not limited to, peoples care plans, medicines management, the premises and falls. Audits showed that complaints, safeguarding concerns and incidents and accidents were managed, responded to promptly and used to improve the service. Detailed records were made of accidents and incidents that had occurred and the immediate action taken, to prevent similar incidents from recurring. The documentation showed that management took steps to learn from such events and had taken measures to ensure they were less likely to happen again. In addition to the quality monitoring processes referred to above the registered manager had instigated a head of departments meetings on a weekly basis, to discuss ongoing maintenance, housekeeping, and care issues. An action plan was in place and updated at each meeting, with timescales for completion of actions.

People, their relatives and friends were positive about the improvements made to the service. One person told us, "It's improved here" A relative told us, "I have been visiting this home for years, it's not like a care home it's like a family. I have a lot to thank the provider, registered manager and staff for, they are quite a unique combination of people, motivated efficient and dedicated to providing a good service. I can't speak highly enough about the service. It's a lovely place."

The registered manger told us they worked on the floor alongside staff whenever possible so that they could monitor the day to day culture and standard of care provided. They told us, they led by example, emphasising to staff that, "We work in the resident's home, they don't live in our workplace." People, their families, friends and staff described the culture in service as 'homely and friendly.' The deputy manager told us, "We are a family, we have a good staff team, who all pull together including catering and domestic staff, if we need anything, we get support from the provider and the registered manager. The registered manager is fantastic, they have given me so much support, I wouldn't be here without their support and belief in me."

Staff told us they felt well supported by the registered manager. The chef told us, "Things have improved here, with lots of discussion and support from the provider and manager." One member of staff told us, "I really like working here, the registered manager is really nice, things have been better for the residents and staff since they have been the manager. They help out on the floor, when needed and they are a real help to staff." Other comments included, "I love working here, I feel supported by the management team, they are both very supportive," and "We have a good team, we have to work together, if not it affects the residents."

Staff told us they received regular supervision and annual appraisal regarding their performance. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. Records showed that regular staff meetings were taking place, as well as head of department meetings. The minutes showed areas of concern were addressed, new policies and procedures discussed, ideas encouraged and good practice shared. Additionally, twice weekly

management team meetings were held to share information and to monitor standards. This created an opportunity for the registered manager to meet with staff, including night staff to discuss issues face to face rather than by e-mail. The registered manager told us and the minutes of meetings showed staff were involved in the development of service. For example, staff had been involved in deciding on if Broome End was a suitable place for a person with complex needs, requiring permanent residential care, following a period of respite. Their needs and the support required was discussed and all staff agreed with the right support from the specialist dementia team, they would offer the person a trial period.

People, their families and friends were involved in making decisions about the service and asked for their feedback. For example, the last 'Residents meetings' minutes dated 16 October 2018 showed discussion and feedback had been sought about recent events and future activities. Satisfaction surveys were sent to people and their families, most recent being a Resident satisfaction surveys which focused on their dining experience. Additionally, relatives were provided with the details of an independent website available on the internet for people to compare care homes and post reviews of their experience of services. A review of the website reflected there had been three reviews in 2018, all containing positive feedback posted about the service. All stated they would be extremely likely to recommend Broome End. Comments included, "My [Person] was admitted in February and from that date, to this I have nothing but praise and gratitude for the care and attention they have received. The friendly atmosphere and dedication of all the staff is a great comfort and the compassion my [Person] receives is wonderful," and "Care workers and management are very helpful and approachable, they update me on any changes and if I have any concerns they listen and take action. They always put [Person's] care first, I have watched the team support other residents and their families, their patience and their caring attitude are a tribute to Broome End. I would not want my [Person] in any other care home and when I ask if they are happy? They say "yes". That's all you want to hear from a loved one."

The registered manager told us they had developed good working relationships with other care home managers in the local community, sharing and discussing ideas and keeping up to date with new legislation. They were aware of their responsibility to liaise with the local authority where safeguarding concerns had been raised and such incidents had been managed well. They had worked well with a number of specialist services, such as the Mental Health Team, the GP, district nurses and attend community events, such as Prosper. The community matron told us, since the registered manager had taken over management of the service, things had generally been the up, they have worked hard to improve the service, and had gone above and beyond to make the improvements needed. They told us the registered manager demonstrate good leadership, and that communication between the service, and district nurse team had greatly improved."