

Bradbury House Limited

The Old Rectory

Inspection report

Chewton Hill
Chewton Mendip
Radstock
Avon
BA3 4NQ

Tel: 01761241620

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance the Care Quality Commission (CQC) follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service

The Old Rectory accommodates 10 people who have a learning disability and/or autistic people. The service is located in a large house in the rural village of Chewton Mendip. Despite being a large service, it was operated in line with some of the values that underpin the Right support, right care, right culture guidance and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autistic people using the service can live as ordinary a life as any citizen.

People's experience of using this service and what we found

Based on our review of the key questions safe and well-led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support

The home was reliant on agency staff that did not always know people well or were confident to support people when out of the home. This meant at times the service could not fully meet the underpinning principles of Right support, right care, right culture and we could not be assured that people who used the service were able to live as full a life as possible and achieve the best outcomes.

People were supported to have some choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice.

Staff did everything they could to avoid restraining people. The service recorded when staff restrained people, and staff learned from those incidents and how they might be avoided or reduced. The provider's behaviour specialist was supporting the staff to ensure appropriate support was being delivered.

People were supported by a key worker who met with them to seek their views about how they wanted to be supported. People relied on staff to enable them to go out in the community to ensure their safety and that of others.

Right Care

People's medicines were mostly managed safely. Other health and social care professionals were involved in the care and support of the people living in the home. Referrals had been made to the local community

learning disability team.

Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

People received care from staff that had been through a thorough recruitment process. Staff were caring in their approach towards people.

Right culture

Not everyone was happy with the care and support and the relationships within the home. Two people said they did not like all the staff or the people living in The Old Rectory. They said they had raised this with the manager and were being supported to find alternative accommodation. The person said some of the staff had left. Relatives were mostly positive and said since the new manager had been in post, they had seen improvements in communication.

There had been a lack of leadership in the home. There had been no registered manager at the service since January 2021. The new manager started working in the home in October 2021. They had an improvement plan they were working towards. However, due to workforce pressures they had not managed to address many of the areas for improvement due to supporting people themselves because of the lack of permanent staff and high agency usage.

Staffing was not always planned in respect of people's individual needs which meant they were not always receiving their one to one support.

The provider and the manager had failed to implement a robust system to monitor the quality of the service. Improvement in areas of risk management had not been fully implemented in respect of the property, fire and cleanliness.

The home was in a rural area, however, there was good public transport links to Bristol, Bath, Wells and other neighbouring towns. There was a shop, a café and public house in the village.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was good (published 12 December 2018).

Why we inspected

This inspection was prompted by a review of the information we held about this service. The inspection was prompted in part due to concerns received about an increase in incidents within the home, staffing and governance arrangements. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report. You can see what action we have asked the provider to take at the end of this full report. For those key questions not inspected, we used the ratings awarded at the last

inspection to calculate the overall rating.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to systems to monitor risks in relation to fire and infection control, staffing and the governance arrangements.

We recommend the provider consider current guidance on supporting people with a learning disability and autistic people to improve people's experience.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

The Old Rectory

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection team consisted of two inspectors.

Service and service type

The Old Rectory is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us.

The Old Rectory is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a manager, but they were not registered with the Care Quality Commission. An application had been received and was being processed.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with four people who used the service about their experience of the care provided and spent time with others observing interactions with staff. We spoke with five members of staff, the manager, locality manager and the providers behaviour specialist. We spoke with three relatives and contacted three health and social care professionals about their experience of the service.

We reviewed a range of records. This included three people's care records, daily records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff rotas and quality assurance records.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- People were not cared for by suitable numbers of staff. Staffing had been reduced due to recruitment and retention. There were ten staff vacancies, these were being covered by agency that had been block booked to ensure continuity and familiarity for people.
- We saw that there were three occasions in the last three months where the minimum staffing was not met. There were two occasions when one of the night staff had provided sleep in cover rather than a waking night. This put people at risk of harm especially in light of people's high complex needs.
- We were told pre-pandemic the home was staffed with eight staff during the day and five staff up to 10pm. This was confirmed on a fire risk assessment dated January 2021. The manager told us the minimum staffing was now four staff during the day and three staff up to 10pm. This was confirmed within the home's business and contingency plan.
- People had additional hours for one to one support totalling 63 hours per day. Two people had ten hours per day to meet their assessed needs. When there were four staff working in the home this individual level of support could not be given to people as per their commissioned care package.
- Staff told us, whilst regular and familiar agency were used, regular staff had to offer more guidance and support to the agency staff to ensure the shift ran smoothly. A member of staff said on occasions people had not been able to go out due to agency staff not knowing them very well and were not as confident as the regular agency and permanent staff.
- Staff told us the lack of staff had impacted on other areas of the home such as cleaning and administrative tasks. A member of staff said the home had domestic and catering support in the past, but these posts were no longer filled. They said if these posts were filled it would at least help, enabling staff to focus on supporting people.
- We observed staff being attentive to people's needs and supporting people to go out, such as the farm, a trip into Bristol, another person went shopping and another went out for lunch. However, one person asked the inspector on three occasions to take them out in the car. We were told this person would be supported later if there was enough staff. We checked when returned on the second day and the person had been supported in the evening to go for a drive in the car.

The failure to ensure sufficient skilled staff were deployed to provide people's care and support was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The provider completed checks on the suitability of potential staff. This included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment

decisions and help prevent unsuitable people from working in care services. One member of staff's application could not be found.

Assessing risk, safety monitoring and management

- People were not always kept safe. This was because checks on the fire equipment, and risk assessments around fire were not being reviewed. Not all staff had participated in a fire drill to ensure they knew what to do in the event of a fire. The last fire drill was in November 2021. We have made a referral to the local fire safety officer.
- We saw a fire door that had an edging strip missing. This meant that in the event of a fire this area was compromised. Carpet in the hallway was heavily stained and worn on the stairs, which exposed the wood of the stairs. This was a potential trip hazard and put people at risk of falls. We saw the pedal action bin in the kitchen not working, which meant staff had to open the bin with their hands, which posed an infection control risk. There was a bin with no lid or pedal action in the staff room again posing an infection control risk. These failings put people at risk of harm.
- The manager was unable to show that the annual electrical appliance testing had been completed. This was due in March 2022 and overdue by two months at the time of inspection.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the visit to the service, the provider sent through confirmation that checks on the boiler and gas had been completed as this was not available in the home.
- An external fire assessor had completed a risk assessment in March 2022. There were a number of recommendations that had been made to ensure the safety of people in the event of a fire. An improvement plan was in place with timescales and who was responsible for each specific area. These had been prioritised with a date of achievement the end of June 2022.
- Risks to people had been assessed and recorded. We reviewed examples of risk management in relation to activities, traveling in vehicles and the environment. A majority of the risk assessments we looked at had not been reviewed since 2019, however they remained relevant.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules had not been completed for the months of March, April or May 2022 in respect of the kitchen or people's bedrooms. There were no cleaning schedules for other areas of the home. There was no evidence of increased cleaning of high-pressure points in relation to the COVID-19 pandemic. Areas of the home would benefit from a deep clean such as the kitchen especially over the cooker, the extractor fans and doors throughout the home. There was staining on carpets in hallways and on the stairs.

Systems were not in place to ensure the home was clean and repairs were completed promptly. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were somewhat assured that the provider was preventing visitors from catching and spreading infections. When we arrived, we were told to wait in the main entrance where people living in the home were actively passing by. We had not been checked in respect of our COVID-19 status such as temperature check and lateral flow testing. This put people at risk due to this delay. Staff were unable to locate the thermometer to enable them to promptly check our temperature or that of people living in the home or other visitors.

- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service. There had not been any new admissions to the service.
- We were assured that the provider was using PPE effectively and safely. Staff were observed wearing PPE appropriately. There was sufficient supplies and areas for the staff to put on and remove this safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- The manager demonstrated they had followed the government guidance on visiting arrangements. Friends and family were able to visit the home with no restrictions. This allowed people to stay in contact with their relatives during the COVID-19 pandemic.

Systems and processes to safeguard people from the risk of abuse

- Not everyone at the service felt safe. A person told us they did not like living in the home and said another person living in the home had threatened them. They told us their social worker was looking for alternative accommodation. Another person said they did not like living in the home because they did not always get on with people in The Old Rectory.
- We discussed this with the manager, who provided assurances that this was being addressed and they were working with the local authority and safeguards had been put in place to protect people. The manager said they were looking at the compatibility of the people living in the home to ensure people's safety individually and collectively as a group of people.
- We received some mixed feedback from relatives over how safe they thought their family members were. One relative raised some concerns over incidents that had occurred between people.
- A member of staff said most of the time people get on well but like everyone when living together, people have their disagreements. Another member of staff said, "One person knows the buttons to push to upset others." They said to safeguard people they were always aware of where the person was so that early intervention could take place by using distraction.
- Staff knew what they had to do to keep people safe and reported any concerns to the manager. Staff were confident the manager would take action to ensure people were safe. Staff were aware who they could report concerns to outside of the organisation if they felt they were not listened to. Appropriate referrals had been made to the local safeguarding team.
- The level of supervision and support for people was not in line with their commissioned hours. Safety of people was being compromised due to the reduction in staffing. There had been an increase in incidents between people and one person's heightened anxiety, which was having an impact on others.
- Some people could become anxious, leading to incidents where they harmed other people, staff or the environment. There were detailed plans in place about how staff should support people at these times.
- Whilst staff said restraint was the last result on occasions people were being restrained to ensure their safety and that of others. We saw on one occasion staff had not followed the person's support plan in relation to when restraint should be used. This had been addressed by the manager and as a consequence of the level of incidents in the home, the provider's behaviour specialist was working in the home full time. We were assured by the action that had been taken. Both employed and agency staff confirmed they had received specific training to support people with heightened anxiety and the use of restraint.
- The manager understood their responsibility to keep people safe and report concerns to the local authority safeguarding team. The manager was able to tell us what safeguards had been put in place to protect people including the dismissal of staff, liaising with people's social workers and involving other

health and social care professionals.

Using medicines safely

- Some aspects of medicines management needed to be improved.
- One person had been prescribed medicines to be taken 'when required' [PRN]. The medicines had been prescribed to support the person at times when they were anxious. Whilst there was some guidance on how the medicines should be given on the person's medicine administration record (MAR), there was not a specific PRN administration protocol in place. PRN Protocols give staff information on when and how the medicines should be administered. MARs indicated the medicines had been administered appropriately. The manager completed a PRN protocol for the medicine during the inspection.
- Medicines were stored safely and securely. Information was available on how people liked to take their medicines and people's MARs were completed when medicines were administered.
- Where people were prescribed creams and ointments, these were dated when opened and there was guidance for staff on where and how these should be applied.
- Staff received training and assessments of competency were conducted annually.
- The manager was aware of the guidance about reducing medicines using the principles of STOMP. STOMP stands for stopping over medication of people with a learning disability or autistic people pledge with psychotropic medicines.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Applications had been submitted and were monitored to ensure they had not expired.
- One person had a condition as part of their deprivation of liberty authorisation. The manager told us they were aware that this was outstanding and was planning to review in respect of the person's capacity to have access to keys to the pantry and other areas of the home.

Learning lessons when things go wrong

- Accidents and incidents were recorded and reviewed by the manager, the provider's behaviour specialist and the senior management team. The behaviour specialist analysed incidents for themes and trends and where things could have been approached differently. They told us they had identified areas of development for the staff team and they were working with them to make improvements. Staff commented positively about the support they received from the behaviour specialist.
- Team meetings were used to debrief the team and look at any lessons learnt.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance arrangements were not robust. Audits were not being completed in line with the provider's expectation. There had been only one medication audit completed since November 2021. The provider expected this to be completed monthly. There were no environmental or infection audits being completed at regular intervals to ensure the home was safe. There was an expectation that this was completed quarterly. The last one had been completed in January 2022 and the one prior to this in July 2021.
- The lack of auditing and checking had failed to identify the infection control risks in respect of cleaning, poor record keeping relating to the one to one support hours for people, the lack of fire checks and fire drills and poor documentation in respect of the cleaning in the home.
- The provider's representative completed a quality audit covering the CQC's five key questions of safe, effective, caring, responsive and well led. The manager was able to share the one completed in February 2021. The lack of checks on the home meant the provider could not be assured that the quality of the service was being maintained or improvements being made. This was riskier in light there was a period where there was no registered manager working in the home and then a new manager had started in post.
- The manager did not have full oversight of the safety of the service. Action required from servicing and maintenance visits were sent to the provider's head office and the manager was not always aware when they would be completed or if they had been completed. These included actions from an external fire assessor and the checks completed on the gas and boiler.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate there were effective systems to monitor the service by the provider or the manager. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a new manager in post who was not yet registered with CQC. However, they had submitted their application, and this was being processed. They had been in post since October 2022. There had been no registered manager since January 2021.
- The manager had developed an action plan in November 2022 that included 50 areas for improvement such as training, supervision of staff, better rota planning of staff to improving staff morale. They had also identified the need to complete monthly medication audits, that people's care documentation needing updating including risk assessments and for the home to be more homely. Some areas had been addressed whilst others were ongoing.

- Due to the home experiencing workforce pressures, the manager was often supporting people living in the home to ensure their safety. This had meant they had not been able to carry out many of their management responsibilities. In response the locality manager told us they were assisting in reviewing and updating people's care plans and associated documentation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The new manager told us they were working with the staff to change the culture of the service, which included people being more involved in their care and the running of the service.
- Some areas of the home were not homely and were in need of redecoration. The manager was consulting with people about the décor of the home and what improvements could be made to the garden. One person was going to be more involved in the fire checks around the home. Staff confirmed people were involved in cooking, domestic chores and were supported to do things they enjoyed.
- People's care plans were person centred and detailed. However, improvements were needed to the records that captured people's one to one time with staff. They did not capture the individual's allocated one to one support or that it was a meaningful activity. For example, in one person's record it stated, an hour charging up their electronic device, for others it was support during a mealtime and for another person the record stated they had spent time with four others in the garden. This did not lend itself to person centred care demonstrating there was positive outcomes for people or that people were receiving their one to one hours of support.
- Some people were not living with people they would choose and sometimes they had to wait to go out due to staffing. Therefore, this did not show due regard for the statutory guidance Right Support, Right Care, Right Culture.

We recommend the provider consider current guidance on supporting people with a learning disability and autistic people to improve people's experience.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager was aware of their responsibility to inform relatives and other stakeholders when things had gone wrong.
- The manager was aware where concerns had been identified, appropriate notifications should be sent to the CQC as required by law, and to the local authority.
- Staff knew they had to report concerns to the registered manager and were confident that these would be acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The manager was meeting with staff on a monthly basis to discuss improvements in respect of roles, communication with people and learning from incidents. Staff spoken with said the manager had an open-door policy and they felt confident going to them with concerns or suggestions.
- We observed staff supporting and engaging with people. On the day of the inspection people were supported to go out and asked how and where they wanted to go.
- People's views were sought via meetings with their allocated 'key worker'. The manager told us they were working towards making these meetings more consistent. Where people indicated they were not happy a 'discussion' form was used to record their feelings and prompt any required action.
- Relatives knew who the manager was, and they commented positively about them. One relative said, "[Name of manager] hasn't been there that long, I find them really good, they are trying to pull the place

together, they are doing a really good job." Another relative commented, "[Name of manager] has been in touch a few times, they are very approachable, friendly, informative and easy to get hold of."

- The provider's quality assurance policy stated they carried out an annual survey with people and family members to gain their views of the service provided. People's relatives confirmed they received these. However, these were not sent to us when requested.

Continuous learning and improving care

- We contacted the provider's representative in relation to staffing who confirmed they were liaising with the local authorities in respect of the workforce pressures. They confirmed that staffing had been reviewed in light of the pressures the home was experiencing and had been reduced. There was ongoing recruitment and incentives for staff to refer a friend and to retain existing staff.

- Training was monitored by the manager. A training matrix was seen, which evidenced that there were some gaps in training. The manager provided assurances that training had been booked for staff where this had expired or because they were new to the service.

- A recent external fire risk assessor had identified that all staff should complete fire warden training to ensure that on every shift there was a competent person. At the time of the inspection, there was only one member of staff (the manager) was trained as a fire warden. The provider's action plan said this would be completed by 28 June 2022.

- A clear vision for the direction of the service by the provider, which demonstrated a drive for improvement and to ensure people achieved the best outcomes possible was not evident. We requested from the provider an improvement plan for the service. The managing director said there was not one in place. However, they said they were looking at décor and staff retention and remuneration.

Working in partnership with others

- Feedback from professionals indicated that communication in the home could improve. One professional said, "There has been a lot of service managers through my time and that has created difficulties in knowing whom the best person to contact is or getting any response at all". They did say they hoped this would improve under the direction of the new manager.

- Referrals were made to health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not done all that is reasonably practicable to assess and mitigate risks. This included checks on the fire equipment and checks on the electrical appliances.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>The provider failed to ensure the premises were clean. Cleaning schedules had not been completed.</p> <p>Systems were not in place to ensure the home was in a good state of repair. There were no regular environmental checks in respect of the building. The carpet on the stairs was unsafe.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failed to establish and operate governance systems to identify shortfalls in the quality of care provision and safety.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider failed to ensure sufficient numbers of suitably qualified staff were deployed across the service.</p>

