Wiltshire Council

Bradbury House

Inspection report

The Portway
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bradbury House provides planned and emergency short term respite care for up to ten people with a learning disability, some of whom may have additional physical care needs. At the time of the inspection there were seven people including one emergency admission having a short break.

This inspection took place on the 14 March 2018 and was unannounced.

This is the first time the service has been rated Requires Improvement.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

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.

Quality Assurance systems were in place to assess and monitor service delivery. Outcomes were assessed and where shortfalls were identified an action plan was devised. Although people's records were securely stored, they were not complete or up-to-date for some people. This was not identified within the audits of outcomes. The views of relatives were gathered about the respite care service.

People told us the types of day to day decisions they were able to make. The staff we spoke with were knowledgeable about the day to day decisions people made. Mental capacity assessments and best interest decision were not complete for all complex decisions. There were inconsistencies with the assessments of capacity for complex decisions and Deprivation of Liberty Safeguards (DoLS) applications.

Steps were taken to ensure medicine systems were safe. People told us staff administered their medicines. Medicine profiles included a photograph of the person and essential information such as known allergies and how the person preferred to take their medicines. Medicine administration records (MAR) charts were signed by staff to indicate the medicines administered. Where "as required" also known as (PRN) medicines were prescribed procedures were not devised on the administration of these medicines.

Risk management systems were mostly effective. Risks were assessed and for some people risk assessments were developed on how to minimise the risks. However, moving and handling risks assessments were devised but lacked detail.

The staff we spoke with were knowledgeable about people's individual risks and the actions needed to

minimise the risks. Individual risks to people included self harm, risk of malnutrition and for mobility impairments. Epilepsy profiles were in place for people at risk of seizures.

There were people who expressed their anxiety and frustration using aggression and self-harm. Staff told us and training records confirmed they had attended positive behaviour management training. Behaviour management plans included the triggers and the actions staff must take to prevent situations from escalating.

Incidents and accidents were reported and were analysed to identify emerging patterns and trends.

The safety of the living environment were regularly checked to support people to stay safe. For example, fire risk assessments, fire safety equipment checks and fire training for staff.

Safeguarding processes in place ensured people at the service were safeguarded from abuse. Members of staff told us and training records showed safeguarding of abuse training was attended. The people we spoke with said they felt safe and the staff gave them a sense of safety.

Staffing rotas were designed to ensure staffing levels were appropriate to meet the needs of people on respite care.

Staff received feedback through regular team meetings where people's needs, staff's roles and responsibilities were discussed as well as information shared. The staff were supported to develop the appropriate skills and knowledge needed to meet the needs of people accommodated. The training records provided showed staff had attended training which the provider had set as mandatory. One to one meetings with the registered manager were regular to discuss performance, personal development needs and concerns.

The staff were knowledgeable about the aims of the organization. They knew how these values were embedded into practice. Staff told us the team was stable and they worked well together. They told us the registered manager was approachable.

Care plans were in pictures and words and detailed people's preferences. They reflected people's physical, mental, emotional and social needs. People were aware care records were held.

We saw people seeking staff attention and reassurance. Staff knew people's preferences and how to approach people in a sensitive manner. The relatives we spoke with said their family members showed signs they had enjoyed their respite stay when they returned home.

We made recommendations regarding maintaining records up to date including when required medicines procedures.

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 deteriorated to Requires Improvement.
Records lacked detail and medicines to be given when required lacked guidance to staff on when to administer these medicines.

Is the service effective?

Good

The service remains Good

Is the service caring?

Good

The service remains Good

Is the service responsive?

Good

The service remains Good

Is the service well-led?

Requires Improvement

The service deteriorated to Requires Improvement.
Quality assurance arrangements were not always applied consistently because assessment outcomes had not identified that records were not always accurate or up to date.

Staff were aware of the values of the organisation and said the team was stable and worked well together.

People's views about the service were gathered

Bradbury House

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 the 14 March 2018 and was unannounced. At the time of the inspection there were seven people having short term care at the service.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection was completed by one inspector. We spoke with two people and two relatives by phone. We spoke with three staff, the registered manager and the area manager. We looked at documents that related to three people's care and support and daily records. We also reviewed staff's training records, duty rosters, organisational policies and procedures and quality monitoring documents.

Requires Improvement

Is the service safe?

Our findings

People told us the staff administered their medicines. People's individual medicine files included their photograph to ensure staff were able to recognise the person. Essential information such as known allergies and how the person preferred to take their medicines were recorded. Medicine administration records (MAR) charts were signed by the staff to indicate that medicines were administered as prescribed. Staff told us and training records confirmed they had attended medicine training.

Procedures lacked detail for medicines prescribed to be taken when required also known as (PRN). The purpose of the medicines and the maximum dose to be administered for pain relief was not always specified. The symptoms to look out for and when to offer the medicine was not always detailed in the protocol. For example, whether the person was able to ask for the medicine or observing for signs that pain relief was needed. Following the inspection NICE guidance was provided to help the registered manager devise protocols.

We recommend that the provider reviews the policy for the use of PRN medication and ensures that it is implemented.

While records were kept secure they were not always detailed. Moving and handling risk assessments lacked detail for people that used wheelchairs with staff support to move around within the home and the community. The support needed from staff for each movement was not listed in the assessment. We also noted that two people were using bedrooms equipped with overhead hoisting system for transfers and specific bath aids for people with mobility needs. . However, the moving and handling risk assessments did not specify the equipment being used, the number of staff needed and how staff were to support people with transfers. We brought this to the attention of the registered manager during feedback and they agreed with our findings.

Risk assessments were in place to support people to be more independent. The staff were knowledgeable about people's individual risk and the actions needed to reduce the risk. Staff said risk assessments were in place for example travelling in the home's vehicle, supporting people with mobility impairments and epilepsy.

When people showed signs of distress due to anxiety and frustration the staff knew how to manage difficult behaviours. Some people expressed anxiety and frustration through aggression and self-harm. A member of staff told us how difficult incidents were managed, which included "withdraw" from the situation and distraction techniques such as offering refreshments. Another member of staff said where people became anxious the staff maintained a calm atmosphere, where appropriate gave people time and ensured the safety of others.

The behaviour management plan for one person detailed the early signs of anxiety and how staff were to respond to the behaviours presented. The behaviour management plans included the triggers which may include pain and the preventative measures to avoid situations from escalating. The waking night protocol

for another person detailed the behaviours exhibited during periods of high levels of anxiety. The triggers for extreme anxiety included "waiting, crowds and too many choices" and the response from staff to these triggers included avoiding crowds and distraction techniques.

Arrangements in place ensured people stayed safe from avoidable harm. Fire risk assessments listed the factors that determined the hazards of fire along with the actions needed to ensure the safety of people. Records of fire safety checks and practices showed steps were taken to reduce the potential of fire at the service. Individual fire safety procedures gave staff guidance on how to support people to evacuate the property safely. Alternative action was detailed that staff could take for people that refused to leave the property.

Incidents and accidents were documented and investigated by the registered manager to assess for emerging risk and patterns. Where there was learning from incidents action was taken.

Safeguarding systems, processes and practices were developed and implemented to safeguard people from abuse. The people we spoke with said they felt safe and the staff gave them a sense of safety. Staff told us and the training records confirmed they had attended safeguarding from abuse training. Staff knew the types of abuse and were aware of their responsibility to report allegations of abuse.

There were sufficient numbers of suitable staff to support people to stay safe and meet their needs. The registered manager said agency staff were used to maintain staffing levels as there were vacant posts. Recruitment of new staff was in progress and before they worked at the home checks were undertaken to ensure their suitability.

The rota in place detailed the staff on duty throughout the day and night. The registered manager said the staffing rotas were devised depending on the needs of people having respite care. On the day of the inspection there were seven staff on duty in the morning, four staff in the afternoon and one staff on induction. At night there were two staff awake and two staff asleep but available if needed. There was one to one staff support at all times during the day and night for some people at risk of epilepsy seizures and behaviours that staff found difficult to manage.

Good

Is the service effective?

Our findings

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

Mental capacity assessments for care and treatment were not always completed and where decisions were these were not recorded accurately. Where people lacked capacity to make decisions mental capacity assessments were completed for staying at the service. These assessments were for continuous supervision and restricting people's freedom to leave the home without supervision. However, not all aspects of people's care and treatment were assessed. For example, weight reducing diet, disguising medicines and to take photographs. The registered manager and staff told us mental capacity assessments were being reviewed and updated. While action plans evidenced the comments made by the registered manager further improvements in this area were needed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found inconsistencies in mental capacity assessments for restricting people's freedom and best interest decisions taken.

The staff told us they had attended MCA training and records confirmed the training attended. Members of staff were knowledgeable about the day to day decisions people were able to make. A member of staff said "We help people make decisions." They explained that some people were giving visual choices to support them with decision making.

People received consistent person-centred care and support when they were referred to use or move between different services. The registered manager said referrals were received for respite care and emergency accommodation. They said social workers' care plans were provided before offers of respite care were made. A member of staff explained that tea visits were organised before respite visits were arranged. They said during tea visits the staff "begin to develop support plans" Staff said a communication book was used to keep in contact with main carers and other services such as day care provision.

New staff had an induction into the role they were to perform. A member of staff said their induction included shadow shifts with experienced staff as they had progressed roles within the home. They had attended training such as positive behaviour management before working as a support worker and were registered to start on a vocational qualification in care which recognises qualifications and units by awarding credits.

Staff were supported to develop their skills and the knowledge needed to deliver effective care and support. Staff said there was mandatory training set by the provider and they had attended refresher training to

maintain their knowledge base. They also attended specific training to ensure people's changing needs were met. For example, positive behaviour management and epilepsy awareness training.

Regular one to one meetings with the registered manager were held. Staff said one to one meetings were eight weekly and at these meetings there were discussions about their role, training needs and issues of concerns. A member of staff said "We discuss anything and everything."

People's dietary requirements were catered for during their respite stay. People told us they enjoyed the meals served and staff told us they prepared menus and the meals. A member of staff said there was flexibility with the menus and people's preferences were catered for. A whiteboard in the kitchen listed people's dietary requirements and preferences. Information was also available on the meals and snacks to be provided for people going to day services.

Guidance in relation to eating and drinking was provided by Speech and Language Therapists (SaLT) where people had complex needs with eating and drinking. For one person the guidance provided detailed the textured diet to be served to reduce the risk of choking. This guidance was also available in the kitchen with additional information on the utensils and crockery the person used to eat their meal.

The chalk board in the dining room listed the menus for the day. A pin board next to the menu board included photographs of meals and food items that related to the day's menu. For example, pictures of bread, bowls of porridge and mugs of hot drinks. We observed the tea-time meal and saw staff giving individual attention to people. Members of staff where appropriated used adapted utensils and crockery to support people with eating their meals. Staff used the appropriate method of communication to assist people with their meals for example, British sign language (BSL).

People were supported to access healthcare services where necessary and to receive ongoing healthcare support. Staff told us the arrangements when people became ill included contacting their GP. Emergency services and 111 were contacted for guidance and where people were out of region they were registered with a local GP as a temporary patient.

Health action plans in place detailed the support received by people from healthcare professionals with their ongoing health. Hospital passports detailed important information on how healthcare professions were to deliver care and support in the event of a hospital admission. The person's medical condition, their ability to make decisions, how the person communicated and food preferences were documented.

Profiles and emergency management plans were in place for people with epilepsy, which detailed the types of seizures. This included the aids and equipment which alerted staff that the person was having a seizure and the assistance staff should provide during seizures. For example, administering rescue medicines and contacting emergency services for prolonged seizures.

People's individual needs were met by the adaptation and design of premises. However, there were parts of the property that were in need of remedial action and decoration. The property was purpose built with bedrooms and communal spaces on the same level. There was level access into the property with aids and facilities for people with mobility needs and wheelchair users. Two bedrooms had overhead tracking hoists and shared an adapted bathroom. The other five bedrooms were single and en-suite.

Good

Is the service caring?

Our findings

People told us the staff were kind to them. One person said "I like the staff, they are nice to me." This person also told us they kept in contact with family while they were staying at the service. Other people were not able to tell us about their experiences about living at the home. A relative said "They look after my [family member] brilliantly and I have a good working relationship with the staff." Two relatives we spoke with said their family member "looked happy to go" and returned "happy" from respite care. They said to them this was an indication their family member enjoyed their stay.

The staff were aware that people needed to feel that they mattered, were listened to and information was presented in way that was understood. A member of staff said they spent time getting to know people and took part in activities, which ensured they developed relationships with people. Another member of staff said they used humour and personal care was not rushed. This member of staff also said "I make people laugh at me and with me. We enjoy our job and want to make it a good place."

The registered manager ensured respectful and empathetic behaviour was promoted within the staff team. They said "Everybody is treated in a person centred way. People have choices and make decisions. Staff care about people and the compliments from relatives prove it. There is an open culture, staff are trained and their practice is observed."

We saw staff showed concern for people's wellbeing and responded to their needs quickly. The staffing levels were organised to ensure people had support from staff as needed. Where people needed individual assistance one to one staff were assigned. We observed staff's presence in communal areas and they participated in the person's preferred activities.

Care plans were in pictures and words format and detailed "what was important" and "how best to support" the person. For example, family networks and medical conditions. For some people it was detailed how they expressed their emotions and their likes and dislikes. When staff spoke to people their preferred first name was used. Staff ensured they were at eye level when they communicated with people and explained the actions they were taking before delivering care. We saw a member of staff communicated with one person using British Sign Language (BSL).

The relationships between staff and people receiving support demonstrated dignity and respect at all times. People's rights were respected. People told us staff knocked on their bedroom door before entering. A member of staff said "People were treated with respect and as equals." Another member of staff said people were addressed in a polite manner. They approached people in a calm manner and gave them time and space during personal care.

Good

Is the service responsive?

Our findings

People received care that was personalised and responsive to their needs. The relatives we spoke with confirmed care plans in place were based on how staff were to deliver care and treatment. Care plans were in pictures and words format and reflected people's physical, emotional and social needs and their preferences.

One page profiles for people on respite care detailed the day care provision they attended during the day, their interests and how staff were to support them. The "About me" plan for one person listed the relationships that mattered to them, medical conditions and previous addresses. For another person their "About me" plan detailed their home arrangements and family network. For some people the signs of emotional distress and illness were also included with, the triggers of these behaviours and how to prevent them from escalating.

Daily routine care plans included people's preferences, their ability to meet aspects of their care and the support needed from staff. For one person their morning routine detailed their preferences. For example, the preferred sequence for meals and personal care, and specific instructions such as having the light on during the night. For another person their daily routines care plan included how they preferred to have their hair done.

The community care plans for one person detailed the local facilities they accessed with staff support. Their preferred activities were listed, which included shopping trips and bus travel. Their goals for future travel experiences and relationships were part of the care plan.

The health action plan for one person indicated they were on a weight reducing diet. A care plan was missing on how this person was to be supported to lose weight. The registered manager told us they used information received from the previous placement. Although one person was on a weight reducing diet and was losing weight a care plan was not in place for this. This meant staff were not given guidance on how to support the person to reduce their weight, the reasons for this and how their weight was to be monitored.

Staff said care plans were devised by senior staff and all staff read care plans. A member of staff told us the care plans formats were to improve as part of service development. Handovers of information and any shift changes of staff occurred daily. Staff completed individual daily sheets on the direct care provided, activities and meals served.

People were supported to follow their interests and take part in activities that were socially and appropriate to them. One person told us how they spent their day at the service. They said "I like watching films and DVDs". When people arrived from their day care services we observed people using the games room. We saw one person was watching DVDs and another person playing games on a hand operated system, which they played with their feet. In the games room people had access to games, puzzles and a ball pit. The registered manager and staff told us facilities were to be improved. A disused room was to be converted into a sensory and quiet area. They said this facility was to be made available to other people using Wiltshire Local

Authority respite services.

The people we asked knew who to approach with concerns. One relative said "All issues were ironed out during initial respite visits." Another relative said concerns were initially raised with their social worker then with the registered manager. The complaints procedure was available to people and relatives in the Bradbury House Statement of Purpose. They said "My only concern is the lack of activities; they seem to sit and watch television all day." We saw the registered manager had responded in writing to concerns raised and included the outcome to their investigation. The registered manager said there was no further discussions with the complainants about the complaints and had assumed satisfaction with the outcome.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post. The staff said the registered manager was "professional and approachable". They said the team worked well together, resolved conflict quickly and in a constructive manner. There were regular visits from senior managers to monitor the quality of service delivery.

Quality assurance systems to assess and monitor the delivery of care were in place and were based on the Care Quality Commission (CQC) Key Lines of Enquiry (KLOE). For example, safe, effective, caring, responsive and well led. Where shortfalls were identified an action plan was devised on how to meet these outcomes. Mental capacity assessments were due to be undertaken for specific decisions where people lacked capacity to make them. Health and Safety action plans for areas identified at medium and high risk included the timescale for when checks and practices were to take place. The checks included the testing of portable electrical equipment and infection control audits. Our findings in relation to records were not identified in the quality assurance system. For example, moving and handling risk assessment lacked detail and a care plan was not in place for one person on a weight reduction diet. The registered manager agreed to audit records to ensure they were accurate and up to date. We recommend that the service seek support to ensure records are accurate and up to date.

There was learning from incident and accident investigations. Since 2018 there were four incidents of behaviours that staff found difficult to manage and one accident. The registered manager said staff were trained in managing difficult behaviours. There were behaviour management plans, which gave staff guidance on how to consistently respond to the behaviours presented. One person had sustained an injury and the registered manager told us the actions taken to prevent further reoccurrences. The registered manager told us thermometers were available in bathrooms to prevent scalds and burns. This meant staff were able to ensure water temperatures were at the specified temperature.

The staff were knowledgeable about the values of the organisation and knew how these were embedded into practice. A member of staff said "People's needs are paramount" and "Training ensured people were at the centre of their care." The registered manager said there was an expectation that staff adhered to the values of the organisation and explained how these were upheld. They said having an open door policy, training and one to one supervision ensured staff worked in a professional manner. that the registered manager also told us "Although I don't shy away from addressing poor performance, the staff were praised for the work they delivered and where there were errors these were discussed."

Arrangements were in place for staff to receive feedback from the registered manager in a constructive and motivating way. Staff meetings were regular and there was a set agenda for the most recent meeting. The minutes showed areas discussed included medicine systems, training, recruitment and people using the service. Where staff had not attended the meetings they signed the minutes to indicate their agreement with the decisions made. Questionnaires were used to gain the staff's views about the service. The registered manager was to address in writing the recent result from feedback received with emphasis on progression and job security.

There was open communication with people and those that mattered to them. The views of relatives were recently gathered using questionnaires that were in words and picture format. Five relatives responded and their feedback was based on respite arrangements, food and CQC reports. The registered manger said the CQC report was on display and relatives were made aware of its location. We saw copies of the CQC report in the foyer of the property.

The registered manager recognised the need for continuous improvement to manage sustainability and future performance. They said more demand was anticipated with the closures of other services that provided respite care within the region. The service type was to be developed to provide respite care for younger adults and care leavers. Regarding learning from incidents registered manager said there was provision of training and equipment to improve the care and treatment people received. The registered manager said they ensured sustainability by ensuring respite care was offered when available. For example, when visits were cancelled the registered manager said the vacant slots for respite care were offered to relatives where available.