

Wiltshire Council

Bradbury Manor

Inspection report

Nursteed Road
Devizes
Wiltshire
SN10 3AF

Tel: 01380732620

Date of inspection visit:
30 January 2016
01 February 2016

Date of publication:
16 May 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Bradbury Manor provides planned and emergency short term respite care for up to 10 people with a learning disability, some of whom may have additional physical care needs. At the time of the inspection there were five people having respite care. This service was last inspected in October 2013 and all standards inspected were met.

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.

Members of staff had a good understanding of risks and had received training to ensure they were able to use specialist equipment such as suction and percutaneous endoscopic gastrostomy (PEG) tubes. Staff said they supported people who were at risk of choking, pressure ulcers, people who experienced seizures and for people with mobility needs. Risks were not always assessed and some risk assessments lacked detail. For example, risk assessments were developed for people at risk of aspiration (food particles entering the lungs) but lacked detail on how and when staff were to use equipment such as suction to prevent aspiration.

Medicine systems did not protect people's safety. Staff said their competency to administer medicines was tested annually. Medicine procedures lacked detail on how to protect people from unsafe medicine. For example, developing protocols for "when required" medicines. People were prescribed with "when required" medicines which included pain relief, medicines for maintaining PEG tubes and for people with nebulisers. Protocols were not developed from the guidance provided by specialists. This meant the staff did not have all the guidance needed to administer medicines "when required" by the person.

People's capacity to make specific decisions was not always assessed, such as the use of audio monitoring systems. Staff had accepted feedback from relatives who did not have power of attorney for care and treatment. Records demonstrated people were vulnerable in the community and needed staff support. We noted there were systems to exit the home and people were not aware of the code to leave the home without staff support. Deprivation of Liberty Safeguards (DoLS) applications were not made for continuous supervision. This meant staff were not working within the principles of the Mental Capacity Act (MCA) 2005.

The views of people were gathered and their feedback was discussed at customer meetings. The manager used this feedback to make improvements to the service. Audit visits from the regional manager were completed every three months. Audits were targeted, for example medicine audits. Where shortfalls were identified action plans with timescales were developed. However audits had not identified staff lacked understanding of the principles of the Mental Capacity Act (MCA) 2005 and that support plans and risk assessment were not in place for all aspects of people's care and treatment.

Staff were knowledgeable about the day to day decisions people were able to make and during our visit we

saw staff enable people to make choices. We observed good interactions between people and staff. Members of staff knew people's preferences, their likes and dislikes and how they wanted to be addressed. Support plans were not always developed on all aspects of people's needs and guidelines were not always kept together.

Safeguarding of vulnerable adults from abuse and whistleblowing procedures were on display. This meant members of staff had access to guidance on the types of abuse and the actions to be taken for suspected abuse. The staff we spoke with were able to describe the types of abuse and the actions to be taken if they suspected abuse. The two people we spoke with said they felt safe and the staff made them feel secure.

People and relatives said staffing levels were good. People said they had the attention they needed. Staff said the staffing levels were good. They said staffing rotas were organised on the dependency needs of people on respite care as some people needed one to one support.

Staff said training was good. They said as well as attending essential training set by the provider, other training was delivered to meet people's specialist needs.

People were helped with their ongoing health. Good working partnerships were developed with healthcare professionals that share the care of people. Hospital passports were in place. These gave medical staff key information needed to deliver care and treatment in the event of an admission to hospital.

Members of staff said the team worked well together and the registered manager was approachable.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

Risks were not always assessed. Risk assessments on minimising the risk and for people to take risks safely were not developed.

Medicine management systems were not always safe. Protocols were not always developed for administering "when required" medicines.

Sufficient levels of staff were deployed to meet people's needs and staff knew the procedures they must follow if there were any allegations of abuse.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

People's capacity to make specific decisions was not always assessed.

Staff showed a lack of understanding of the principles of the Mental Capacity Act (MCA) 2005. Members of staff accepted the feedback about their family member's capacity to make decisions from relatives without power of attorney. Where restrictions to people's liberty were in place the manager did not seek legal authorisations from the supervisory body. .

Staff attended mandatory training set by the provider and other specific training to support people's changing needs. Staff benefitted from one to one meetings with the manager.

Is the service caring?

Good ●

The service was caring.

People received care and treatment in their preferred manner which respected their human rights.

Members of staff were respectful and consulted people before they offered support.

We observed positive interactions between people and staff

Is the service responsive?

The service was not consistently effective.

Support plans were not developed for all aspects of people's needs. Some support plans lacked detail on how to meet people's needs.

People were assisted to participate in community and in house activities.

No complaints had been received, from relatives and members of the public, since the last inspection.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Quality assurance systems to monitor and assess the quality of care were in place but they were not always effective and had not identified shortfalls in the service.

Systems were in place to gather people's views.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

Requires Improvement ●

Bradbury Manor

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 30 January and 1 February 2016 and was unannounced.

The inspection was completed by one inspector. Before the inspection we reviewed information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with two people who use the service, one relative, three staff and two relief staff. We gave feedback about the service to the registered manager and area manager by phone on 1 February 2016. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service.

Is the service safe?

Our findings

Staff were aware of the actions needed to minimise risks to people's health and wellbeing. Two members of staff told us before an admission, risks were assessed and action taken to maintain people's health. For example, staff attended training and sought guidance from healthcare professionals to ensure they had the skills to meet people's specific needs. However, risk assessments and support plans were not developed from the guidance given and training attended.

Risk assessments for people at risk of choking were in place. Eating and drinking risk assessment listed the foods to be omitted from the person's diet and the thickeners to be used in fluids. However, risk assessments and support plans were not in place for people with percutaneous endoscopic gastrostomy (PEG) tubes and for people having suction. This meant people were at risk from harm because the guidance on how and when it was appropriate to assist people with their healthcare needs was not in place.

Staff said moving and handling risk assessments were in place for people with mobility needs. They said they had attended training to ensure appropriate moving and handling techniques were used. Mobility risk assessments gave staff guidance on the equipment and the number of staff needed for each manoeuvre.

Systems of medicine management in place were not consistently safe. One person told us the staff administered their medicines. Members of staff signed medication administration records (MAR) charts to show the medicines they had administered. Guidelines on administering medicines were not kept together in the medicine file. For example, instructions on supporting one person to maintain their PEG tube were found in different places. Support plans were not developed on how staff were to assist a person with PEG tubes. We found some guidance in the communication book, other information in the handover folder and other information in the medicine file.

Medication administration procedures lacked detail about the support people needed to take 'when required' medicines. Some guidance on administering medicines were held within the medicine file but they were not drawn together into a protocol. For example, protocols for nebulisers to be taken up to four times daily 'when required' were not developed. A GP letter dated 2013 gave staff some guidance on using the medicines when there was breathing difficulties with secretions. The guidance had not been reviewed and lacked detail on when to administer the medicine. A member of staff said although a protocol was not in place the person was able to say when the medicine was needed.

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

Two people said they felt safe staying at the service and staff made them feel secure. Safeguarding procedures were on display. The procedure gave staff guidance on the action to be taken if they suspected abuse which included the contact details of statutory bodies. Members of staff knew the types of abuse people may experience and the actions they must take if they suspected abuse. Staff were confident any allegations of abuse would be taken seriously and acted upon.

Staffing rotas were based on people's level of need. One person and their relative said "there is loads of staff and there is consistency". Staff said requests for respite care were made in advance and the rotas were developed depending on people's needs. For example, some people had one to one support while others were more able and the ratio was lower. Staff said there were vacancies and relief staff were being used to cover vacant hours. A relief member of staff on duty during our inspection said they were given an introduction to the service which included familiarisation of the building and they signed records to confirm their understanding of safeguarding procedures.

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 legally authorised under the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People were helped to make daily decisions. Staff said people were able to make decisions about the times to rise and retire, meals, activities and what they wore. They said the person's preferred method of communication was used to assist people with making decisions. One person with capacity gave consent for bed rails to prevent falls but consent for audio monitoring equipment was not gained.

People's capacity to make specific decisions was not always assessed by the staff at the service. For example, the staff had accepted the feedback from a relative without power of attorney to make decisions about care and treatment that their family member had capacity. There was inconsistent information about one person's capacity to make decisions. For example the decision for Do Not Attempt to Resuscitate (DNAR) dated June 2015 was reached with the person and their relative which the medical professional signed. However, other correspondence for the same person from a medical professional stated this person lacked capacity to consent to anti-epileptic medicines.

A member of staff said people were accompanied in the community but was not certain on the actions to be taken if staff support in the community was refused. Records showed the people at the service were vulnerable in the community and needed staff support. The risk assessments developed for community access indicated that some people were accompanied by staff because they were vulnerable in the community. The consent section for people to sign their risk assessments for community supervision was not signed by people and for one person we saw recorded they were not able to make complex decisions. For another person the access/mobility assessment stated because of "the lack of understanding of risk and dangers and level of vulnerability XX would not be able to access the community independently". DoLS applications to the supervisory body were not made for people subject to continuous supervision in the community.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had "about me" support plans, which described the person's usual behaviour and the triggers that indicate to staff their behaviour was escalating. Staff said there were people who at times refused care and treatment for example, oral hygiene. They said people were not forced and when they refused they were given time and then staff would try to support them again. One person said when people exhibited behaviours others found difficult the staff asked them to leave the area. They said they felt protected by not

being in the presence of people whose behaviour had become difficult. Another person said they became frustrated at times and they chose to go to their room and listen to music.

People's dietary requirements were met. One person said they had a choice of meals and their preferred diet was catered for. A relief member of staff said information on people's likes and dislikes was kept in the kitchen. People were informed about the day's menu which we saw on display in the dining room. Menus to meet people's dietary needs were devised. We saw a wide range of fresh fruit and vegetables, tinned and frozen food.

People were supported with their on-going health care needs. People having respite care were receiving care and treatment from more than one service for example GP, dietician and community nurses. Staff said there was multi agency working and information about people's healthcare provided by other agencies was shared with them. They said people were supported with appointments if they were organised at the time of their respite care. Reports from healthcare professionals were sent to the service to ensure they were kept informed about people's on-going health. Where people became ill during their respite stay emergency services were contacted for advice.

Is the service caring?

Our findings

Two people said their care was delivered in the way they liked. People were able to visit the service before respite care was offered. This meant people had an opportunity to experience and familiarise themselves with the service before a respite stay was arranged. Staff said during transitional visits they were able to get to know people and their likes and dislikes. One member of staff said relative's input where appropriate was gained. They said "we can't deliver the service if we don't have that information" and that the aim was for people to have positive stays by supporting their individual needs.

The approach staff used depended on the situation. For example for some people staff used humour to interact with people. We saw discussions with people about the day's events. One person asked staff to help give feedback on their experience of the service. Staff said building trust ensured people felt they mattered. They said consistency of staff made people feel secure which then gave them confidence in the staff's ability to deliver their care and treatment.

Daily routine support plans and profiles were developed and described the routine of the person, their likes and dislikes and how staff were to support them. The things that were important to people were part of their profiles.

People were supported to maintain contact with relatives. One person on an extended stay said they had visits from relatives. Support plans gave staff guidance on how people were to be assisted to maintain links and relationships during their stay.

Records in place gave staff guidance on how people liked their care and treatment to be provided. Life stories described people's family histories, their early years education and their background history before their stay at the home. A member of staff said knowing people preferences ensured the person was at the centre of their care and treatment.

People's rights were respected by the staff. One person said the staff knocked on their bedroom doors before entering. A member of staff said people were respected by the way staff communicated with people. They said confidential information was discussed in private, keys to bedrooms were provided and staff confirmed they always knocked on bedroom doors before entering..

Is the service responsive?

Our findings

Support plans were not developed on all aspects of people's care needs. For example, support plans were not developed on how to assist people who needed assistance with eating and drinking, for people at risk of aspirating and for people who experience seizures. Staff said before people were admitted support plans were developed. This meant support plans were not updated where people's needs changed. For example, the support plan was not updated for one person with percutaneous endoscopic gastrostomy (PEG). The staff said they received guidance and training to deliver care and treatment to people as people's needs changed.

We found guidance was available but it was not always kept centrally. Documentation was not kept together, easily accessible and information was not always kept in care records. Guidelines were found in separate places and not drawn together into a support plan. Guidance on the use of prescribed thickeners was not included in the support plan for another person at risk of choking. For example, eating and drinking guidelines gave instructions on the thickeners to be used and the emergency response flow chart instructed staff to refer to choking guidance. However, the choking guidance was held in the medicine file kept in the medicine room and separate from other information kept in the care records in the staff office. This meant staff did not have all the guidance needed to provide care and treatment to meet people's needs.

Personal care plans for some people said what worked well for the person, their preferred routine and how their care needs were to be met. Staff said there were handovers when shift changes occurred and at staff meetings people's changing needs were discussed. A member of staff said they were told about people's changing needs during handovers and where they were assigned to work with specific people. A relief member of staff with good working knowledge of people said they read the support plan of people they were assigned to work with. We found guidance on meeting people's needs were not part of their support plan. Members of staff said relief staff did not participate in complex procedures. This meant new staff needed guidance from staff on where to locate the appropriate guidance to meet people's needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said people continued to participate in the community based activities during their respite care stay. On the day of our inspection some people decided to have lunch out. A member of staff said one person made the decision on the day's activity. Some people said they were happy to go for the "ride" and have their meal when they returned. One person on an extended stay said they participated in day care activities.

The two people we asked said they would approach the staff with complaints. Staff said relatives with complaints usually contacted the registered manager. They said where people approached them with complaints, they endeavoured to resolve their concerns where appropriate. A member of staff told us that when people approached them with concerns the complaints procedure was followed. The complaints procedure was on display in the home. No complaints had been received since the last inspection.

Is the service well-led?

Our findings

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.

Audit visits from the regional manager were completed every three months. Audits were targeted for example medicine audits. Where shortfalls were identified action plans with timescales were developed. However audits had not identified staff lacked understanding of the principles of the Mental Capacity Act (MCA) 2005 and that support plans and risk assessment were not in place for all aspects of people's care and treatment.

Quality assurance systems in place were effective. The views of people were gathered and their feedback was discussed at customer meetings. The manager used this feedback to make improvements to the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Support plans were not developed on how staff should meet people's changing needs.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make specific decisions was not assessed. Staff accepted feedback from relatives without power of attorney to make decisions on a family member's capacity. People were subject to continuous supervision but Deprivations of Liberty Safeguards (DoLS) applications were not made to the supervisory body.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always assessed and risk assessments were not developed to minimise the risk and for people to take risks safely. Medicine systems were not consistently safe. Protocols were not developed on the administration of "when required" medicines. Medicine procedures lacked detail on the safe administration of medicines

