Methodist Homes

Bradbury Grange

Inspection report

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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

This inspection took place on 6 and 7 April 2016 and was unannounced.

Bradbury Grange is a care home which provides care and support for up to 50 older people. There were 36 people living at the service at the time of our inspection. People cared for were all older people; some of whom were living with dementia and some who could show behaviours which may challenge others. People were living with a range of care needs, including diabetes and Parkinson's. Many people needed support with all of their personal care, and some with eating, drinking and mobility needs. Other people were more independent and needed less support from staff.

Bradbury Grange is a large domestic-style house. People's bedrooms were provided over two floors, with a passenger lift in-between. There were sitting/dining rooms on the ground and first floors. There was a large enclosed garden and adjacent garden room to the rear.

The service did not have a registered manager in post at the time of our visit and had not had one since December 2015.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.

Bradbury Grange was last inspected on 30 September and 1 October 2015.They were rated as inadequate overall at that inspection and placed into Special Measures. The provider sent us regular information and records about actions taken to make improvements following our inspection.

At this inspection we found that significant improvements had been made in some areas. In others, however, the changes made had not completely addressed the issues.

Assessments about individual risks had not always been followed through into practice; leaving people exposed to continued risk of harm. Some people's needs had not been consistently met in relation to their healthcare or well-being.

The principles of the Mental Capacity Act (MCA) 2005 had not been applied in some cases; which led to people's consent not being appropriately obtained.

Auditing carried out for the purpose of identifying shortfalls in the quality and safety of the service had not been wholly effective.

People's safety had been protected through cleanliness and robust maintenance of the premises. Fire safety checks had been routinely undertaken and equipment had been serviced regularly.

There were enough staff deployed to meet people's needs and they had received appropriate training and supervision to help them carry out their roles effectively. Staff were caring and responsive to people's needs and interactions between staff and people were warm and respectful. Recruitment processes had been followed to ensure staff were suitable for their jobs.

People reported enjoying their meals, and any risks of malnutrition or dehydration had been adequately addressed. There were a wide range of meaningful activities on offer and a proactive volunteer group provided extra support and funding for outings and special occasions.

The interim manager was widely praised by people, relatives and staff for his commitment to improving the service. We found a more open, transparent culture amongst staff and management and the provider had displayed their improvement plans prominently. People knew how to complain but said they felt no need to as, "Things have been turned around here".

As this service is no longer rated as inadequate, it will be taken out of special measures. Although we acknowledge that this is an improving service, there are still areas which need to be addressed to ensure people's health, safety and well-being is protected. We identified a number of continued breaches of Regulations. We will continue to monitor Bradbury Grange to check that improvements continue and are sustained.

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 had not always been appropriately mitigated to ensure people's health and safety.

Medicines had not always been managed safely.

The service was clean and hygienic throughout.

Maintenance and safety checks on equipment had been regularly carried out.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights had not always been protected by proper use of the Mental Capacity Act.

People's healthcare needs had not always been properly met.

Training and supervision for staff had been carried out regularly and was effective in practice.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and were considerate of their dignity, and were observed engaging with people in a kind and gentle way.

People were encouraged to be independent where possible and were given choices about their care and support.

People's wishes for the ends of their lives had been carefully documented.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints had been handled informally in the main; and there were no records of responses in those cases.

A wide range of activities was on offer and people were protected from social isolation wherever possible.

Care plans reflected people's preferences for care and treatment.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits were not wholly effective in identifying shortfalls in the safety or quality of the service.

Feedback had been used to improve the service

There was an open and transparent culture and people, relatives and staff felt able to speak candidly to the interim manager.

Bradbury Grange

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 6 and 7 April 2016 and was unannounced. The inspection was carried out by five inspectors and a pharmacy inspector.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider had also sent us regular action plans following the last inspection.

We met and spoke with 18 people who lived at Bradbury Grange and observed their care, including the lunchtime meal, medicines administration and activities. We spoke with nine people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with eight of the care workers, kitchen staff, volunteers, the interim manager, the Quality Business Partner and the provider's Regional Director.

We 'pathway tracked' twelve of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for three other people.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

During this inspection people told us that they felt safe. One person told us," I am very happy, I feel safe and reassured by the staff". Another person said, "Oh I do feel safe here. If you fall over you press the red button: I have fallen twice and staff came to help me". A relative commented, "I very much feel mum is safe here. Mum's had the odd fall from health related reasons, and the staff always call me or my sister straight away. They've contacted paramedics, kept me up to date with the doctor's visits and kept me in the loop". Another relative said that there had been, "Massive improvements" since our last inspection; and they now felt happy to leave their relative between visits.

At the last inspection on 30 September and 1 October 2015, we reported on a number of areas where people's safety in Bradbury Grange was not ensured. At this inspection we found significant improvements had been made overall; in keeping people safe. However, risks to individuals had not always been assessed or minimised appropriately.

A range of assessments had been made about the different risks to people. For example; about their mobility, their nutrition and their skin condition. Some people were living with diabetes that was controlled by diet and/or tablets. Their care plans recorded that blood sugar levels should be tested regularly to ensure that they were within acceptable limits .However, this had not happened for three of the people we checked. In one case, the blood sugar had last been tested in August 2015 and another person's in October 2015.The interim manager accepted that this had been overlooked and contacted the diabetic nurse immediately to arrange for testing to recommence. Although people appeared well, the lack of blood sugar monitoring had placed them at potential risk of diabetic complications.

Another person's care plan contained assessments about their behaviour towards staff. The guidance about how to deal with this was not sufficiently detailed to allow the situation to be properly managed and the risk minimised. Charts had been completed to document incidents of challenging behaviour to staff; but matters had escalated, resulting in a safeguarding incident between this person and another in February 2016. The matter was referred appropriately to the local authority safeguarding team for investigation, by the interim manager, but the incident might have been prevented if the risks had been adequately addressed at an earlier stage.

A further person had been hospitalised recently due to a fall. The assessment in their care plan about the risk of falls had not been updated to reflect the current position when they returned to the service. This person was not wearing a call alarm, even though staff told us that everyone should be wearing or have access to one. The interim manager put this right immediately when we brought it to his attention, but there was a risk that this person could have fallen again while alone and been unable to raise the alarm.

The failure to properly assess and minimise risks to people is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people had been assessed as at high risk of falls, and care plans gave detailed instructions to staff

about how they should support people to mobilise. We observed that staff used appropriate equipment and methods when assisting people to move; as set out in risk assessments. People had been referred to special falls clinics for advice to help prevent further falls, and staff documented daily checks on people's footwear; to make sure it was properly fitting and did not present a hazard to them.

At our last inspection, risks to people's skin had not been appropriately minimised through the correct use of special air cushions and mattresses. At this inspection air cushions and mattresses were set at the correct levels for people's weights in every case. Record sheets had been introduced to document that these items of equipment were checked by staff daily; to ensure that they had been accurately set. Staff were able to tell us how they carried out the checks and understood the need for the equipment to be correct; to provide therapeutic benefit to people.
Armchairs and other furniture had been changed since our last inspection to make it more suitable for people with limited or restricted mobility; and to prevent the possibility of them slipping from seats. Adapted, raised seats were now fixed to toilet bowls securely which helped minimise the risk that people could lose their balance while seated on loosely-fitted ones.

At the last inspection we found that medicines had not always been properly managed to protect people from risk. At this inspection improvements had been made in the way in which medicines and creams were stored, administered and recorded. However the effectiveness of some people's medicines had not been properly monitored. The records of three people who had been prescribed blood-thinning medicines were reviewed. These records contained blood test results, subsequent scheduled tests and the exact dose to administer. However, care plans lacked details of the signs and symptoms of over or under treatment and any supporting actions including summoning expert advice. There was a risk that staff would not recognise when people needed to be seen by a GP or understand the point at which this should happen.

Another person had been prescribed medicine to help with agitation. Although there was clear information in their care plan about how to manage episodes of challenging behaviour associated with the agitation; this had not been cross-referenced with the instructions for the use of the medicine. Staff needed a full picture of how the agitation was to be relieved, in order to be able to support the person appropriately.

The failure to properly manage some medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Homely remedies were available to people from a stock held in the service. These are medicines the public can buy to treat minor illnesses like headaches and colds. The service had agreed a list of homely remedies with GPs to ensure that people were not given anything which might interact with any existing, prescribed medicine being taken. However, there were inconsistencies between the remedies authorised by the GP, remedies stocked and the provider's local and national policies. There was no evidence that people had received homely remedies inappropriately, but the conflicting information created a risk that this could happen.
We recommend that a full review of homely remedies and relevant policies is undertaken by the provider.

Prescribed creams were now kept in lockable cabinets within people's bedrooms, which kept them safe from the possibility of being applied too frequently. Staff were observed completing records to show when and where creams had been applied. The information about creams was accurate and consistently completed.

Other medicines were stored securely in designated, locked rooms or within lockable trollies. The temperature of medicines and creams was monitored and recorded daily by staff. This ensured that

medicines remained fit for use. Assessments had been made about risks associated with people's medicines; including whether people were able to self-administer their tablets and creams. Information was held for each person about 'How I take my medicines' and 'My ability to express my need for medicines'. These documents gave staff important guidance about individual people's needs and preferences and also about how different people communicated pain. Staff we spoke with were knowledgeable about medicines and were able to tell us about any allergies people had to particular medicines.

At the last inspection we reported that morning medicine rounds were taking too long to complete; which meant there was a risk that there may be insufficient gaps between some people's doses. At this inspection the interim manager explained that rounds had been split between two staff on each floor; where previously the whole medicines round was carried out by one staff member on each floor. This had the effect of dividing the workload between the staff, reducing the overall time it took to administer each person's medicines. The service had also sought external pharmacy advice about how they could improve on the timeliness of medicines rounds. As a result they had staggered the times that people received their morning medicines; depending on the times people generally woke up. Staff said this system worked much better and people we spoke with were happy that they received their medicines regularly and when they needed them. Medicines administration records had been completed to reflect the earlier times that some people had their first medicines doses of the day.

At the last inspection we reported that some areas and equipment within the service were not sanitary. At this inspection the service was found to be clean and hygienic throughout. All bathrooms, toilets and communal areas were tidy and clear of any unpleasant stains. Commode chairs and toilet brushes were checked and found to be unsoiled. Toilet brushes had been included on both cleaning schedules and manager's audits to ensure that they were not missed during cleaning rounds. A relative told us," It's cleaned every day and if there's incontinence or an accident they clear it up straight away". "If I take Mum out the cleaning lady gives it a really good clean in her room". We observed cleaning staff using specialist equipment to wash carpets and these staff were a presence throughout the inspection. They reacted quickly to any spills and were thorough in the attention they gave to bathrooms and toilets.

At the last inspection, we had found that people's sheets were not being changed as frequently as some people wished and that records about this were lacking. At this inspection linen rotas were in place to demonstrate that people's sheets had been changed at least weekly, if they wished them to be. People and relatives confirmed that this happened and that they had the choice of when they were changed. The laundry was well-equipped and staff were able to describe how dirty items arrived in the laundry and were kept separate from those that were clean. One person commented, "The house is always clean and they take your washing away and do it. You always get the right clothes back-I've got my name in my clothes".

At the last inspection we found that people had not been protected by robust recruitment procedures; because proper pre-employment checks had not been carried out. During this inspection the files we reviewed showed that recruitment procedures had improved. Application forms listed full employment histories, identity documents were copied and staff underwent background checks before they were allowed to commence employment.

People and relatives told us they were satisfied with staffing levels during this inspection; commenting, "The staff are hardworking, but spend enough time with me. It's not all business, they have enough time for a chat and pop in when they're passing" and "I have noticed a positive difference in the staff, they seem more tuned in and are certainly aware of the support my mother needs. I don't have any concerns".

We spoke with people about how long it took staff to come to their bedroom if they pressed the call bell.

People were confident staff would come when called, they told us they didn't wait for too long and most people thought staff arrived within a few minutes of being called. When asked, none of the people or visitors we spoke with expressed concerns about insufficient staff or that they took too long to respond to call bells being pressed. Some people commented this had "improved". Call bell audits had been undertaken by the interim manager and these evidenced that only one call in the previous month had taken longer than six minutes to answer. Discussion with staff established they were aware of people who may not be able to call for help or use the call bell system. Processes ensured staff actively looked in on them to make sure they were safe. Other passive measures, such as pressure mats and room sensors helped to alert staff if people needed support.

There were sufficient staff with a suitable mix of experience and skills to meet people's needs. Daytime staffing comprised of four care staff per floor and two waking staff per floor provided night support. Staffing allocations ensured a senior carer was always assigned to each floor on each shift. Other staff undertook duties such as administration, housekeeping and maintenance. A chef provided meals supported by kitchen assistants. A new manager had recently been recruited and a new deputy manager appointed. Most staff shortfalls were met through use of existing staff to help to ensure consistency of care. Agency staff were occasionally used when this could not be achieved. Risk and needs assessments formed the basis to determine how many staff were needed. Discussion with the interim manager and a review of staffing records demonstrated staff deployment was a flexible system allowing for additional staff when needed. A second member of staff was allocated to some medication rounds to address concerns that they took a long time to complete. This helped to ensure people received their medicines in a timelier manner and was kept under review by the interim manager.

Observation throughout the inspection found staff were responsive to people's needs. People were supported to eat and drink as needed. Where people needed help to move around the service or required staff to support them to transfer between wheelchairs and lounge chairs, appropriate support was provided. Staff used standing and lifting aids where needed; people were supported patiently with staff providing reassurance and explaining what they were doing. Our observations showed staff were aware of people's support needs and people received appropriate support.

At this inspection staff were able to confidently describe the different forms that abuse may take. Training about safeguarding was up-to-date and staff knew how to raise any concerns about people in their care. Records showed that incidents where people may have been harmed or at risk of harm, had been raised with the local authority safeguarding team. The interim manager had documented occasions when he had sought advice about whether a matter should be raised as a safeguarding issue. This showed that he was proactive in ensuring the correct authority was made aware of any concerns about people. Records of the manager's own investigations into safeguarding incidents were thorough and detailed; and evidenced that input had been sought from other professionals, such as the GP, psychiatric services and pharmacists to help resolve any problems identified.

Accidents and incidents were documented by staff and reviewed by the interim manager. There were clear protocols about people's treatment following falls; including post-falls observations in which staff regularly monitored people to ensure they were not deteriorating in the period immediately following a fall. Action plans had been put in place to prevent further accidents and included referring people to physiotherapy, sourcing mobility aids for them and lowering their beds where appropriate. Following accidents, a raft of assessments and actions had been made to help keep people safe.

Safety checks had been regularly carried out and documented on all equipment and services, including hoists, passenger lifts, gas and electrical systems and water temperatures. Logs showed that environmental

safety audits highlighted any hazards or remedial repairs needed throughout the home and that these had been signed off as completed promptly. People told us that maintenance had improved and that, "A lot of the jobs weren't done properly, or not at all, but the new maintenance man is great." We noted that a light bulb which blew during the inspection was changed immediately and observed pictures being hung in one person's room as they had requested. The maintenance man was enthusiastic about his role and told us how he was contributing to improvements by, for example; using a special type of paint around the service as it provided an easy-clean surface.

People were protected from fire and other urgent risks. Personal emergency evacuation plans were in place for each person and included information about individuals' needs for support and whether they had any cognitive or sensory impairment. The number of staff needed to assist people, any equipment required such as a wheelchair or a walking frame and details about people's awareness of the fire alarm were documented. All personal evacuation plans had been reviewed in January 2016. There was an emergency plan in place for major incidents which had also been recently reviewed. It contained an emergency contact list and details of where people would be evacuated to; as a designated place of safety. Fire alarm testing was carried out weekly and there had been a full fire drill for day staff. There was one planned for night staff to ensure that they were aware of how to manage an evacuation in the event of an emergency. Records of fire drills showed which staff were involved, how long it took for staff to respond and any improvement actions.

Requires Improvement

Is the service effective?

Our findings

People, their relatives and visitors were positive about the quality of care provided. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, "The staff are good and look after me well", "Staff are hardworking" and "The staff are very friendly, professional and considerate". People and their relatives said staff communicated with them well. A visitor commented, "Staff are always welcoming, and are good at keeping me updated about how my relative is". Although people commented positively, we found aspects of the service were not always effective.

Our last inspection found the service was not effective and was inadequate. Breaches of three regulations identified the service did not appropriately establish people's capacity to consent to care and treatment; health and nutritional needs were not always followed up or met and staff had not received appropriate training, supervision and support. We asked the provider to take action to make sure these concerns were addressed. We asked the service to provide regular updates and monitored their progress. During this inspection we found the provider had taken steps to improve; but had not fully met all of the previous shortfalls.

Our last inspection found mental capacity assessments did not meet the requirements of the Mental Capacity Act 2005 (MCA). This was because they were generalised and did not consider specific decisions. Where people were assessed to lack capacity, other care documents, including Do Not Attempt Resuscitation (DNAR) orders, contradicted the findings of the mental capacity assessments. The principals of the MCA were not clearly understood or embedded into everyday practice.

This inspection found new mental capacity assessments forms had been introduced, they considered individual decisions and reflected any help people received to give them the best opportunity of forming their own decisions. However, examination of care plans and discussion with senior staff found although the revised assessment forms had been used for more recent capacity assessments, some care plans still contained old mental capacity assessments that did not meet the requirements of the MCA. Consequently some older mental capacity assessment decisions continued to contradict other care documents. Discussion with senior staff established an imminent review of all capacity assessments was scheduled to address this issue.

Some care plans contained a prominently placed DNAR form. However, not all were fully completed because they did not contain the person's personal details such as their name or date of birth; one DNAR stated that the person was to be resuscitated; and details about people's capacity recorded on the DNAR contradicted other assessments the service had made about their mental capacity. Incomplete or contradictory information contained in DNAR forms presents a margin for serious error. This potentially may result in a person's rights not being respected, their final wishes not being met or no resuscitation attempt being made when it was required.

The failure to appropriately obtain people's consent is a continued breach of Regulation 11 of the Health

and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's weight and health care needs were monitored, however, there were mixed results in terms of action taken by the service. For example, one person was observed to have difficulty with their denture. This person's care plan showed that they had been seen by a speech and language therapist in January 2015 who had recommended a dental review. However, there were no records to show that this had happened and the interim manager confirmed that it had not. This person's weight records showed that they had lost more than 4kgs between December 2015 and March 2016, but they had not been referred to a dietician at the time of our inspection. This person's needs for treatment to their teeth had not been met.

Another person was observed urinating onto the floor on the first day of our inspection. We brought this to the immediate attention of staff who helped the person concerned. However, on the second day of the inspection, the same person urinated again in the same place. This person's care plan recorded that they used continence pads 'Day and night'. There was a note to state that staff should ensure that the person was wearing a pad during the day. This had not happened on two consecutive days and meant that this person's needs had not been properly considered and met by staff.

Care and treatment did not always meet people's needs. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Otherwise people's records showed evidence of regular health appointments and contacts with health professionals intended to ensure their overall health and wellbeing was maintained. These included nurses, dieticians, GP's, dentists, chiropodists and occupational therapists. Staff were familiar with medical advice about how to support people and we saw that advice received was put into practice, for example, the provision of softened meals or thickened drinks. Where people had communication or cognitive difficulties, staff showed awareness of their needs and used appropriate methods, for example, picture cards, to aid understanding and effective communication.

Food and fluid charts were kept in people's bedrooms. These were used where concerns were identified, typically loss of weight or a risk of malnutrition or dehydration. Those seen had regular entries. Nutrition assessments (Malnutrition Universal Screening Tool (MUST) were completed and reviewed each month. Weight was monitored, recorded and, other than the in instance noted, action taken to respond to any weight loss. Fluid charts included amounts of liquids consumed, this was reviewed at staff handover to establish if some people needed extra encouragement to drink or there was cause for concern.

The lunch time meal was well-managed and relaxed. The menu was clearly displayed; visual aid cards and descriptions by staff helped some people make choices about their food. Lunch was a social occasion, with some people eating meals with visitors and staff. Eating aids, such as adapted plates and cutlery were provided to people who needed them. This helped them to eat independently, also promoting their dignity. Table settings included place mats, serviettes, condiments and water. People could also have juice or hot drinks, some people enjoyed wine with their meal. Sufficient staff supported people in the dining areas as well as people eating their meal in their own rooms. Softened or fortified foods were provided where necessary. Kitchen staff held records for each person to ensure individual dietary requirements were known. Where needed, staff were aware of the amount of thickener to put into drinks to ensure they were the right consistency. Daily feedback and consultation about menu choices helped to ensure people were able to give their views about the meals provided. We looked at feedback given about the food, this was mainly positive.

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS), which form

part of the Mental Capacity Act (MCA) 2005. It aims to make sure people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used.

The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. Applications had been made to the local authority for 10 people who lacked capacity to consent to receive care and treatment at the service. Receipt of the applications had been acknowledged and the home maintained regular contact with the local authorities pending their decision making processes. Where for one person a restrictive practice was in place, they were able to tell us they had agreed to the measure, they recognised it was in place to help keep them safe and were happy for it to continue. A DoLS application was not required for this person because they were able to understand and consent to the needs for the restriction.

Staff understood the basis of the MCA and how to support people who did not have the capacity to make a specific decision. We heard staff encourage people to take their time to make decisions and staff supported people patiently whilst they decided. Policies reflected that where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate was required. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service. We saw examples where the advocacy service had been used.

Staff were positive about the training received and were able to tell us how they used it in their day to day role, for example, in relation to skin care to reduce the risk of pressure areas. People told us they had confidence in the staff, thought they were well trained and knew how support them. One person commented, "I have every confidence in the staff, they have given me no reason to have any doubts or concerns in either their commitment or ability". New staff members told us and training records confirmed they were required to complete an induction programme and were not permitted to work alone until they had been assessed as competent in practice. Staff said they were continually supported thorough their induction period.

There was a continuous programme of on-going training for staff. Training records and certificates confirmed the training undertaken. The training plan identified when essential training, such as fire safety, health and safety, manual handling and safeguarding required updating. Staff training included other courses relevant to the needs of people supported by the service such as dementia and diabetes awareness. The service has recently invested in new training resources. This offered staff training to complement the Care Certificate as well as areas such as on going, clinical, mental health and end of life care together with some more advanced areas of practice. Staff rotas confirmed the service gave appropriate consideration to the skill mix of staff when planning the various shifts. This helped to ensure people's needs could be effectively met.

Good

Is the service caring?

Our findings

People and relatives told us that the standard of care people received had improved since our last inspection. One person said, "They're good the staff, they're kind and thoughtful and do things as soon as they can. If you ask them to do something you can depend on them, and when you're dependant on other people that counts for a lot". Another person commented, "They've done a lot of hard work, and there is a brighter feel about the home. The staff have always been good". A relative told us; "Thank goodness you inspected here when you did last time. Things had got really bad, but there has been tremendous improvement since then".

At our last inspection people had not always been treated with dignity. This time we observed staff consistently speaking with people in a kind and respectful way. For example; one person appeared to be confused and staff gently spoke with them and guided them to their room. The staff member did not hurry the person, but walked alongside them at the person's pace; all the time making conversation and effectively distracting the person from their confused state. Another person was brought to the lounge in a wheelchair. Staff asked the person to choose where they would like to sit and helped them to decide in a patient and considerate way. They asked whether the person would like to be near a window, but reminded them that the sunlight was quite strong, and suggested they might like to sit in a quieter space as they had returned from an activity and may like, "A snooze". Classical music played softly in the lounge area and created a calm and welcoming atmosphere. Staff explained what they were doing and the reasons for it when they supported people; for example when assisting people to move using special equipment. This gave people reassurance that they were safe and being looked after.

People told us that staff were respectful of their need for space and privacy on occasion. Some people liked to pray or simply preferred to spend time alone, and we heard that staff were mindful of this and ensured that they did not intrude at these times. Staff always knocked on people's bedroom doors and asked permission before entering; which showed respect for people's right to have a private place of their own. Staff knew how each person liked to be addressed and consistently used people's preferred names when speaking with them. Staff spoke to each other discretely when discussing people's care needs and acted promptly to offer support when needed.

Staff were caring towards people and we observed many positive interactions during the two days of our inspection. There appeared to be a real bond between staff and people; evidenced by the way in which people laughed and joked with staff and were relaxed in their company. One person pretended to tell staff off for having the previous day off. The staff member told the person that they had missed them; and it was a warm and affectionate exchange. A relative told us, "On the whole they are nice girls who work here and very caring and they all seem to love X. Whenever people speak to X, she laughs and the staff are very sweet to her and look after her well. I'm always welcomed here from the manager down". Another relative told us that it had been their loved one's birthday recently and that a birthday cake had been baked especially for them; which they found touching.

At mealtimes, staff were attentive and observant of when people needed support. Staff asked people, "Is

that enough for you or would you like a bit more?" when serving meals, which meant different appetites were catered for. They offered help but also allowed people to manage for themselves if that was their preference. For example; "Would you like me to cut that up for you or are you ok with it? People were encouraged to be as independent as possible in the knowledge that staff were on hand to assist if needed.

Care plans gave staff guidance about giving people confidence by letting them wash their own faces and hands, for example, if they were able. Staff told us that it was important to most people to retain their independence, even in small ways. They explained how they gave people choice wherever possible so that they felt enabled and in control. People were given choices of drinks, meals, clothing, seating and activities during the inspection; and advocacy services were advertised for people who needed more help with decisions or conversations about their care. Some people were living with diabetes and needed to watch what they ate. Care plans recorded that staff should gently remind people of the need to make healthy choices and one person with diabetes told us that they had jokingly asked for a large portion of pudding. They told us it had been refused in a light-hearted and considerate way by the chef; who knew their needs and made sure they were offered something suitable but tasty instead.

People told us that they were involved in their care and care planning. For example, one person said that they had made their own appointment to see the dentist because they were able to do so. Another person told us that," Staff always let me know what's going on and I feel I can ask about anything and get an honest answer". Relatives commented that they were kept apprised of their loved-ones' progress and care needs. For example, a relative said, "I feel listened to. When Mum first came we sat and discussed what Mum likes. I've made them aware of allergies and everything. The DNAR was discussed and Mum said she wants to be resuscitated". Another relative said, "They're very good at communicating with us and we always get emails to keep us posted or ask for our views". Care plans showed that the contents had been discussed with people or their relatives and had been signed to confirm this.

Care plans contained detailed information about people's wishes for the ends of their lives. This was a practical but sensitive record about people's preferences and had been thoughtfully compiled. It included specifics about 'Clothing to be worn on my final journey' and 'Items to take with me', alongside information about funeral directors and family to be contacted. Relatives told us that they appreciated their loved ones' wishes being documented in this way. One said, "It's never easy to talk about these things, but at least we know Mum will get exactly what she wants when the time comes". Another relative commented, "We've had open conversations with the manager about end of life. Everything's in place and that gives us all some peace of mind".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, people and relatives told us that they felt their complaints were not taken seriously or addressed effectively. At this inspection people and relatives told us that this situation had been "Completely changed" .They said they knew how to complain and would not hesitate to do so if they had cause. One person said that they had frequently had to complain in the past but "Things are so much better now, I don't have to". A relative said: "I'd probably talk to the staff if I had a complaint, but I've not had to; and another told us," I keep a close eye on everything, and if necessary I will complain; but I've never made a formal complaint".

The provider's complaints policy was on display and accessible to people and visitors. This described the procedure for dealing with 'Significant or written 'complaints. A number of complaints had been recorded by the interim manager; but these had largely been dealt with informally. As such there were no written responses to some concerns that were raised. The interim manager explained that this was because the complaints had been raised verbally and were treated as "Concerns rather than complaints". However, people and relatives we spoke with felt that any issues raised by them had been managed effectively and they had been satisfied with the responses.

Actions had been taken as a direct result of concerns taken up with the interim manager; and these had been documented. For example; a relative had highlighted that it was unclear whether or when their loved one had a bath or shower. This matter was raised at the next staff meeting and the minutes of this showed that a list had been produced to show these details in future. Another relative had asked for personal care to be delivered in a specific way and told us that this was now happening. This person's care plan had been updated to reflect those wishes.

We recommend that responses to informal concerns are documented in order to provide a full audit trail of the complaints process.

Records of compliments received had been retained. These included comments from people, their relatives and friends. Some of the most recent compliments stated, "Thanks to all the staff for the good job. Heard that it's a very good home", "X thanks MHA [the provider] for the recent improvements at Bradbury Grange" and "X commented on the improvements at Bradbury Grange and feels that the home has come a long way since the last inspection".

At our last inspection care plans lacked detail about people's preferred routines and information had not always been reviewed regularly .At this inspection there had been improvements to care plans so that they reflected people's personal choices and the majority of those seen had been reviewed and updated at intervals. For example; one person's care plan listed exactly which areas they liked to wash themselves and those for which they would require staff support. This showed that care and treatment had been tailored to suit the individual person and was not a generalised approach.

A wide range of activities were available for people to enjoy. The service had a very active volunteers group

that provided entertainment, outings and raised funds for items such as a large summer house that was being erected during the inspection. One person told us, "There is a good art group and they do it in the lounges upstairs and downstairs. We did it yesterday and made crowns for the Queen [90th birthday celebration tea party]". Another person said, "I go to the Thursday coffee morning and we put the world to rights. Some people who don't want to join in with the discussions come just for the company".

An activities timetable was on display in communal areas around the home. People were also given copies to keep in their rooms so that they could choose if they wanted to attend any of the planned activities on offer. Some of the activities listed included quizzes, scrabble, knitting groups and Pets As Therapy visits. Activities were happening on both floors for most parts of the day apart from mealtimes. We observed people engaging in seated exercise sessions and playing board games with staff. There was much laughter during these activities and people told us they enjoyed spending time with one another and staff. Daily activities records were kept for each person; to show what they had been doing and whether they enjoyed it.

Some people did not leave their rooms to join in with organised activities and staff told us that the activities coordinators visited these people to have one-to-one chats if they wished. The activities coordinator said that word search and crossword puzzles were left with people who did not like to join in, and a small prize was awarded to the winner; to try to prevent people from becoming socially isolated. A special pack had been sourced from the Royal Society for the Protection of Birds (RSPB) aimed at encouraging birds and wildlife into the garden of the service, for everyone to watch and enjoy; whether from their bedrooms or communal areas. We heard that an activities survey was being prepared for people to complete, so that activities staff could tailor events to people's preferences.

People's spiritual and religious needs were met through a range of prayer meetings and on-site church services. These happened several times each week and one person told us, " As a Methodist home we are part of the Methodist church circuit which means that ministers quite often visit here, just for a chat; which is lovely". Reflexology and hairdressing services were available to people and we heard that they enjoyed being able to access these and frequently used them.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we reported that people and relatives told us they had no faith in the management of the service. At this inspection, we heard how people felt the interim manager had "Turned things around". Throughout the inspection we heard about the positive changes that had been made. For example; one person said, "I've seen a tremendous change here, a fantastic improvement in the home. It's headed in the right direction now". Another person told us, "The manager listens: which not all managers do-there's been so much improvement and the manager is friendly and approachable". A relative commented, "Very pleasant manager who actually listens to you. He's there for you and deals with what you ask for. He's very efficient and things are so much better here".

Although we found much improvement during this inspection, there were still a number of areas which needed to be fully addressed to ensure people's health, safety and well-being. These issues had been highlighted in the report of our last inspection but had not been completely remedied at this inspection.

Assessments about risks to individual people had not always been minimised; leaving them exposed to continued risk of harm. Not all mental capacity assessments had been updated; meaning some people's did not comply with the requirements and principles of the Mental Capacity Act (2005).People's consent had not always been appropriately sought as a result. In some cases, care and treatment did not consistently meet people's needs because care plan guidance was not followed through into practice or care plans contained insufficient information for staff. The provider's action plan stated that all of these areas had been addressed following our last inspection, but improvements had not been sufficiently wide-spread to protect every person using the service. The interim manager acted immediately in response to our findings during this inspection, but the issues had already been brought to the provider's attention and should have been resolved sooner.

A wide range of audits had been introduced and undertaken with the purpose of identifying any shortfalls in quality or safety. These included falls, weights, skin wounds, infection control and health and safety audits. Some of these had been effective in highlighting areas for improvement and had been actioned by the interim manager. For example; following concerns at the last inspection about the amount of time people waited for call bells to be answered a new electronic system was introduced which changed the tone of the bell to 'Urgent' after six minutes. Audits of response times showed that the interim manager had investigated the cause of any urgent calls and taken appropriate action where needed. Falls audits were thorough and contained meaningful information about how to assure people's safety, for example; by conducting daily checks on their footwear. This process had decreased the number of falls happening significantly since our last inspection. 'Standards Assessments' had been carried out by the Quality Business Partner who also made monthly visits to review quality and safety. They looked at a range of aspects of people's care such as; care and welfare, medication, food and drink and staffing. Each assessment resulted in an action plan and we saw that any adverse findings had been followed up.

However, some auditing was less effective. DNAR forms had been checked but this was only to see that they had been fully completed and positioned appropriately in care files. The audit did not recognise that some

DNARs did not contain proper details to prevent the risk of people's rights being overlooked. Medicines had been subject to several layers of auditing; which had resulted in much-improved management. However, gaps in signatures on medicines administration records had been completed in retrospect as part of the audit process. This meant that when reviewing the records it was not possible to see whether they had been completed at the time medicines were administered or later. Senior staff explained that if gaps in signatures were found, staff responsible would be contacted and asked to sign of the administration record, but only once a reconciliation check had proved the medicines had been given. Care plans had been audited and we found that one of those we checked had also been audited by senior staff in March 2016.Despite this, a number of issues which we highlighted, had not been picked up in the audit process.

Auditing designed to identify shortfalls in care and quality had not been wholly effective; which is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had made significant changes to their management structure in order to provide more robust quality assurance processes in future. This included the introduction of a new Quality Business Partner role; with responsibility for making regular visits to the service to assess safety and quality. An Area Service Manager would also be involved in checking that standards had been improved and sustained. A new home manager had been appointed, but had not started work at the time of our visit; and they were applying to become registered with the Care Quality Commission. During the inspection an existing senior staff member was interviewed alongside other candidates and subsequently promoted to Deputy Manager. The interim manager was to become the Area Service Manager with oversight on this service. The Regional Director explained that it was felt that the interim manager had invested substantial time and energy into developing the service and as such, was best-placed to monitor it going forward.

The provider had mounted a display board in the reception area of the home; to show the last inspection report. Alongside this, the provider had listed the actions being taken to improve and develop the service and invited comments and suggestions from people, relatives and visitors. Feedback had been sought from people in a variety of ways, including through questionnaires, suggestion boxes and at resident and relative meetings. One relative told us, "I attend meetings and they ask us questions around changing meal times for example. That makes us feel involved and they do listen. They're very good at communicating". Actions had been taken following those meetings; such as deciding against terrines of vegetables on lunch tables because people had said they did not want them and introducing daily feedback forms about meals served. Kitchen staff said that these evaluations were useful to them in showing the food people enjoyed most and those meals that were less popular; to inform future menus.

Staff were noticeably more relaxed and open with us during this inspection. They were passionate in speaking about their roles and said they were determined to provide the best care possible. Staff said that they could approach the interim manager at any time with concerns or ideas and that he would be receptive to those. They said they looked forward to working with the new manager to sustain improvements and continue to improve. Staff told us that they had been proactive in helping to develop the service since the last inspection. They spoke with pride about how care delivery was much better for people and that they were happier working in the service than previously. The interim manager was described by staff as, "An amazing influence on the home" and that he "Encourages teamwork and professionalism and we've risen to that challenge".

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care people's needs were not consistently met.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights had or been protected by adherence to the principles of the Mental Capacity Act (MCA) 2005.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Assessments of risks to people had not been properly mitigated.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Auditing used in the quality assurance process had not been sufficiently robust.

The enforcement action we took:

Warning Notice