Wiltshire Council

Bradbury Manor

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Bradbury Manor is a care home that provides planned and emergency short term respite care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service can provide accommodation and personal care for up to 10 people at this location some of whom may have a learning disability and/or additional physical care needs. At the time of our inspection there were five people using the service on the first day of inspection and four people on the second day. The inspection took place on 19 and 20 September 2018 and was unannounced.

At the inspection on February 2016 we asked the provider to take action in response to our findings. A planned inspection took place in June 2017 to follow up on the concerns found at the previous visit. At this visit the service received a further rating of requires improvement and one breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, was found. A requirement notice was made against the service.

At this inspection, although we found improvements had been made in some areas, the service continued to be in breach of Regulation 12 for a third consecutive time. We further identified two new breaches, Regulation 17 Good governance and Regulation 18 Notification of other incidents. The service was rated requires improvement for the third consecutive time and we are considering what action will be taken in response. Full details of CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

A registered manager was in post and available throughout this inspection. 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.

We found that notifications of a safeguarding nature had not always made to The Care Quality Commission. Further to this, evidence of the service's investigations into events were not always recorded, or actions taken and documented, to ensure risks were minimised and people were kept safe.

We reviewed some of the incidents that people had experienced and saw there was not enough detail recorded of the action taken. There was no information on how people were supported, if medical help had been accessed or if actions to minimise the risk of a reoccurrence had been implemented.

The current staffing levels in the home were maintained by a relief bank of staff and agency staff. Staff consistently raised their concerns about the staffing to us.

At times there was a lack of information recorded in care plans for staff to follow. The terminology in care plans and daily records was not always appropriate for the young adults that were being supported. We found that there was no information recorded about how people wished to be cared for if they became unwell or in the end stages of their life.

The provider's quality assurance systems in place had failed to identify concerns in the service for timely action to be taken, to keep people safe. There was a lack of provider oversight of how the service was operating.

The service had worked hard to make improvements to the mental capacity assessments. The assessments showed that people had been appropriately involved in the process and supported to try and understand the decision needing to be made.

People told us they were treated well and staff were caring towards them. We observed that staff were tactile with people and offered comfort through verbal reassurance and gentle touch.

The management and staff valued the importance of maintaining partnerships and links with external professionals and would work alongside them to meet people's needs. We received positive feedback about this service.

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 always safe.

Investigations into incidents were not always recorded, or actions taken and documented, to ensure risks were minimised and people were kept safe.

The staffing levels in the home were maintained by a relief bank of staff and agency staff. Staff consistently raised their concerns about the staffing to us.

The service supported people who had complex needs and at times behaviours could manifest that were displayed by physical or verbal means. Staff were confident in managing and supporting people during these times.

Is the service effective?

Good

The service was effective.

The service had worked hard to make improvements to their mental capacity assessments. The assessments showed that people had been appropriately involved in the process and supported to try and understand the decision needing to be made.

People were supported to eat meals they enjoyed. Staff had consulted people and their representatives about their likes, dislikes and any specific dietary needs.

People were able to see health professionals where necessary, such as their GP, specialist nurse or to attend hospital appointments. People's care plans described the support they needed to manage their health needs.

Is the service caring?

Good

The service was caring.

People told us they were treated well and staff were caring towards them.

We saw staff responded to people in positive ways offering choice and respecting their decisions.

People had been able to develop friendships within the service supported by staff and often arranged to come back when they knew that person would also be staying.

Is the service responsive?

Requires Improvement

The service was not always responsive.

At times there was a lack of information recorded, which staff were aware of in discussion, but not documented in care plans.

We reviewed the complaints log and saw that whilst complaints were logged, there was very little information on how it had been managed or followed up to see if the complainant was satisfied with the actions taken.

Staff were observed communicating effectively during their shifts with each other.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We found that safeguarding notifications had not always made to The Care Quality Commission.

The provider's quality assurance systems in place had failed to identify concerns for timely action to be taken, to keep people safe.

Staff we spoke with told us they felt well supported by the registered manager and able to talk to them if needed.

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 checked 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 19 and 20 September 2018 and was unannounced. The inspection team consisted of one inspector and an inspector from our medicines team. The service had been previously inspected in June 2017 and the provider was found to be in breach of one of the regulations. This is the third consecutive time that this service has been rated as requires improvement and we are considering what action will be taken in response. Full details of this will be reported on after any representations are concluded.

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.

We used a number of different methods to help us understand the experiences of people who use the service. We were only able to speak with one person due to the communication needs of other people. We spent time observing three other people using the service. We contacted three relatives and received feedback from three health and social care professionals about their views on the quality of the care and support being provided.

We spoke and spent time with the registered manager and county manager and six other members of the staffing team. We looked at documents relating to people's care and support and the management of the service. We reviewed a range of records which included three care and support plans and daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June 2017 the service had continued to be in breach for the second time of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because action had not always been taken to mitigate risks to people in areas of temperature controls and medicines. At this inspection although we found improvements had been made in some areas, the service continued to be in breach of this Regulation for a third consecutive time.

We found that safeguarding notifications had not always made to The Care Quality Commission. Further to this, evidence of the service's investigations into events were not always recorded, or actions taken and documented, to ensure risks were minimised and people were kept safe. The registered manager explained that they had not routinely kept details of investigations or minutes of safeguarding meetings, these had been kept at Wiltshire County Hall. The registered manager told us if they had not been part of the meetings, or had been off on leave they were unaware of the actions taken and there was no log of these events to review at the service. This meant the registered persons did not have an overview of how safeguarding matters were being managed within the service to ensure appropriate actions were taken.

We reviewed one incident that had occurred in November 2017 which was ongoing as well as several other incidents since this time. They had been reported to the safeguarding team but only the first incident had been reported to The Care Quality Commission. There were no actions in place at a service level to ensure this person was being kept safe since the incident and further incidents were being prevented. Actions from a safeguarding meeting had not been implemented into this person's care plan to ensure all staff were aware of the procedures they needed to follow and a risk assessment had not been put in place. This meant this person had been left vulnerable during their respite stays at Bradbury Manor due to ineffective management of this situation.

People and their relatives told us they had no concerns and felt safe living at Bradbury Manor and staff were available to help them. One person told us "I like it here, it's a safe place." Relatives commented "I have no concerns" and "I have no concerns over safety, communication is good." We saw the service had information displayed on the immediate actions they should take, should they suspect a person was at risk of abuse and saw staff had been reporting events to the safeguarding team in line with this. One staff member told us "I would speak to the team leader or manager and use the safeguarding flow chart and progress to the next stage." One health and social care professional told us "I have never been into Bradbury Manor and had any concerns, I do feel confident that if I had concerns they would be acted on and dealt with immediately."

The registered manager kept a log of any accidents or incidents that people experienced. This was a brief record which referred to the person's care plan where full details of the incident were then kept. We saw 16 incidents were recorded for this year. We reviewed some of the incidents that people had experienced and saw there was not enough detail recorded of the action taken. There was no information on how people were supported, if medical help had been accessed or if actions to minimise the risk of a reoccurrence had been implemented. For example, one person had been physically assaulted receiving a blow to their head.

Medical assistance had not been considered in light of the person having a potential head injury and there were no details on how this had been managed.

Another person had developed a large bruise. A body map documented the bruise and the daily records stated a large bruise had been recorded on a body map. However, there was no incident form or investigation completed into how this bruise might have happened. Staff told us this person could only have developed the bruise at the service as they had been living at Bradbury for many months, but were unaware of the person falling. This meant there was no system in place to ensure that when incidents occurred they were investigated to ensure appropriate action was taken and people were kept safe.

We spoke to the registered manager about how they managed and documented incidents and safeguarding events. Where other people were involved or staff statements had been taken it was not always appropriate to have this confidential information in one person's care plan if it related to others also. This was able to be accessed by all members of staff and viewed by the individual if requested. The county manager agreed a better system of keeping this information confidential was needed and informed us this would be addressed.

Since the last inspection improvements had been made to the security of medicines. They were being stored in a locked room which was only accessible to authorised staff. The medicines room had also been fitted with air vents to ensure the temperature was appropriate. However, there were no records of the room temperature to show that medicines were being stored at appropriate temperatures. Staff only recorded current fridge temperature. As minimum and maximum temperatures had not been recorded, the provider could not give assurance that medicines were being stored at the temperatures recommended by the manufacturers. When the current temperature had been outside the recommended range, this had not been investigated so medicines requiring cold storage may not have been safe or effective. The registered manager was unaware that the fridge temperature for medicines had been over the safe range 10 times in one month.

When people enter the service, a letter from their GP is needed to confirm the medicines they are taking. There was a record of medicines which were transferred in and out of the service. Two members of staff administered the medicines and recorded this on Medication Administration Records (MARs). We reviewed six MARs and saw there were no gaps in the administration of medicines. One MAR did not have the full medicines list as per the GP confirmation letter. This person had entered the service numerous times and an up to date confirmation of their current medicines was not available. There was no evidence to suggest that their medicines had been stopped. We also saw one MAR where the directions for a medicated cream were not what had been prescribed by the GP and there were no records to explain the change. Staff contacted the GP on the day of inspection to get confirmation on how and where this cream should be applied.

Medicines incidents were being recorded and investigated. However, there was not always an action plan on how the service would share learning to help prevent the same errors re-occurring. The issues identified at the inspection had not been picked up in the yearly medicines audit.

This was a breach of Regulation 12 (2) (b) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were suitable arrangements for storing medicines which required extra security.
People could self-administer their own medicines if they had been assessed as competent to do so. There were suitable arrangements for people who required medicines via an enteral feeding tube. The service had contacted the local pharmacy to confirm which medicines could be taken with which food or drink

products, for people who needed to take their medicines this way. The service had received one response back to this so far.

We saw that care plans contained assessments when a risk had been identified to people's personal safety. The registered manager told us people would be supported appropriately if they chose to do something that increased the potential of risk. They said, "You have to weigh it up, you can't stop someone doing it, we have a risk assessment in place, advise and offer solutions." We saw one person did not have a risk assessment in place for their nutritional needs. This person required staff presence when they ate and had speech and language therapy (SALT) guidelines in place. SALT provides treatment, support and care for people with communication, eating, drinking or swallowing difficulties.

We saw people who needed to be checked on during the night due to care needs or a specific health condition, had a risk assessment in place for this monitoring. Staff completed a record of the checks they made and these were being carried out in line with the care plan instructions. A health and safety checklist had been completed in July 2018 and checks relating to fire procedures, equipment and water were recorded in a log book.

The service supported people who had complex needs and at times behaviours could manifest that were displayed by physical or verbal means. Staff we spoke with felt confident in managing and supporting people during these times and felt supported by the service to do so. One staff member told us, "I have had training in positive behaviour management, it was one of the best courses I have done, it's not about restraining people, it's about not letting it get to that point. We have plans in place for people completed by behavioural nurses, we look at triggers and try to avoid them."

The service had a safe room in situ at one end of the building. The room was designed with protective padding in order to protect someone if they had complex behaviours and there was a risk of harm to themselves. This could be used to help prevent someone going into a mental health hospital and instead be supported within the service. This room had not been used for this reason since our last inspection.

The staffing levels in the home were maintained by a relief bank staff and agency staff. We saw the service was short of 158 hours the week of our inspection which would be covered by permanent staff picking up extra, relief or agency staffing. The management team would also cover shifts where needed and told us staff were good at pulling together to do this. Staff sickness levels in the service were high. One person was off sick on the second day of our inspection. The registered manager told us there was 22 permanent staff but many were off on sick leave. We saw the minutes from a group staff supervision in March 18 which recorded that the high sickness levels, and short staffing levels was affecting the goodwill of staff.

Staff consistently raised their concerns about the staffing commenting, "The staffing is not good, we have agency on every shift. We have good agency workers, however if they have not been in here before and don't know people they are shadowing us. We have had up to six relief and agency staff on shift at once", "Staffing lately has had issues with sickness, it has been challenging but they are fortunate to have relief staff that know people" and "Staffing is difficult, we are down on hours, it's been hard. We have had to say we can't have some people stay that night but they can stay a different night. We are a tight knit team, the people who use our service don't know the staffing issues and don't need to as long as they are happy and safe."

A needs led rota was in place, which changed according to the people coming for respite and their support needs. During September we saw that there were days where up to four staff shifts needed covering. The registered manager told us they were holding interviews later that week and were hopeful there would be some successful candidates recruited.

The service had made improvements to the recruitment information they kept. Staff files were now in place which showed the relevant checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Staff checklists had been put in place but these did not record the dates to ensure that all the necessary checks had been completed.

Although the service told us they were meant to source two references for potential staff, for three staff we reviewed only one reference was in place. The registered manager contacted their human resources department for one of these but they were unable to locate it despite assurances they did have this document.

We found the service to be very clean and homely. An external cleaning company was contracted to provide cleaning to the service. We had raised at our last inspection that there were not any cleaning checklists in place to document what areas of the service had been cleaned, so any concerns could be raised in a timely manner. This had still not been implemented.

Good

Is the service effective?

Our findings

The service had a six-month induction process in which staff completed training, shadowing other staff and spent time going through policies and people's care plans. Staff spoke positively about the induction they had received commenting, "I had an introduction to the service, I was introduced to residents and completed fire safety. I was very happy with the induction", "Induction was really good, when I started, I got shown around" and "The induction was really good, looked at paperwork, policies, procedures and there was a booklet to complete. We did training and a month of shadowing, so really good."

We reviewed the staff training matrix and saw that there were some gaps where training was due. The registered manager explained training had been booked for staff and we saw the noticeboard displayed training sessions for staff to complete. Although 11 of the 22 staff had completed Makaton training, there was no other communication or sensory training offered, despite the service supporting people with this need. The registered manager said a new training coordinator had been appointed and had been more proactive in sourcing training. We saw that the service offered equality and diversity training for staff if they wished to access it, however it was not part of their mandatory training.

Staff received supervision opportunity through means of a group supervision which was offered six times a year. If any staff preferred to have a one to one supervision this could then be arranged with their line manager. We reviewed some of the minutes from these meetings and saw events relating to the service and staff roles were discussed. One staff told us "Supervisions are group ones; however, we can go and talk to the manager any time. The manager is very supportive to us all, we are very well supported."

People were supported to eat meals they enjoyed. Staff had consulted people and their representatives about their likes, dislikes and any specific dietary needs. All information was clearly displayed in the kitchen so staff had guidelines on people's allergies and dietary requests. A weekly menu was displayed which stated for lunch 'Your choice'. Staff explained this was flexible as to what people wanted each day and there may be occasions where some people were out for lunch. The menus changed each week taking into account who might be staying and their preferences and dietary requirements. We saw snacks available for people in addition to their meals and a separate basket containing gluten free snacks for people who needed these. One staff member told us "Some people can make their own drinks and we encourage this independence."

People were able to see health professionals where necessary, such as their GP, specialist nurse or to attend hospital appointments. People's care plans described the support they needed to manage their health needs. The registered manager told us "We have good liaison links with other agencies who show staff how to support particular people." Hospital passports were in place for people should an emergency admission need to be made. This meant important and 'need to know' information about that person would be passed on to the relevant professionals.

Health professionals gave positive feedback about their involvement with the service. Comments included, "The service will ask for input when they are unsure or not confident in supporting a specialist health need",

"I am confident when giving any instructions to any member of the team that information will be fed back to all the team and the instructions will be followed as I have asked, if there is any doubt about the instructions, I am contacted to confirm what it is I am asking" and "Appropriate referrals are made and they work in partnership to produce Health Action Plans and Epilepsy Care Plans."

The service was due to be redecorated and areas maintained. Plans were in place for this work to start shortly. A new shed had already been purchased in the garden. The service had four separate garden areas where people could spend time. One of these gardens was functioning as a sensory garden providing a quiet reflective area for people to sit and relax.

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. The service had worked hard to make improvements in this area. We saw that where people lacked capacity, assessments had been undertaken to support a best interest decision to be reached. The assessments showed that people had been appropriately involved in the process and supported to try and understand the decision needing to be made. The service had involved people's representatives and external health and social care professionals in this process to ensure the decision reached was discussed by people who knew the person well.

Where people had restrictions in place either for their safety or due to a specific health need, a Deprivation of Liberty Safeguard (DoLS) application had been made to the appropriate supervisory body. Staff were observed supporting people who lacked capacity in a gentle manner and continued to offer daily choices. Staff told us "We have to establish if people want to come here and know why they are coming. It is about being able to retain information, some people have capacity in some areas" and "A lack of capacity is someone who doesn't have the understanding to make their own decisions, however it may be their communication is through signing so we try and be clear in communicating." One health and social care professional told us "I have been asked to contribute to mental capacity assessments for Bradbury Manor, and I have asked for staff to contribute to my assessments."

There was confusion around whether one person's relative had Lasting Power of Attorney (LPA) in place for health and welfare. We spoke with the registered manager about ensuring there was understanding around involving relatives in decisions, compared to accepting decisions from relatives who did not have LPA in place.

Good

Is the service caring?

Our findings

People told us they were treated well and staff were caring towards them. One person told us "The staff are helpful." Staff were able to speak about people and their needs easily, demonstrating that they knew people well. Relatives we spoke with praised the service commenting, "Bradbury Manor is very up together, the handover was good, they are very accommodating. Staff are very approachable very knowledgeable, and knew my relative well" and "It is a high quality service, people are well looked after and the facilities are good."

We observed that staff were tactile with people and offered comfort through verbal reassurance and gentle touch. One staff member told us, "I love working in respite care, you're giving people a lot, giving their family a break and giving them a break and helping people to achieve something." Another staff said, "Everyone is trying to do the best for people who come here, they are here for the right reasons. I have worked in a few services and its Bradbury I come back to." One health and social care professional commented, "I have always had confidence in the service and with the staff group working with the people who access their service, all the staff are very professional and want to make sure that the stay at their service is comfortable and relaxing for the service users that are staying there but also for the families who can relax knowing their family members are being well cared for."

People had been able to develop friendships within the service supported by staff and often arranged to come back when they knew that person would also be staying. One staff member told us, "I like the fact people get to meet new people and have friendships, I like the variety and I learn something new every day."

The registered manager told us they were able to ensure people received compassionate care from staff because they worked alongside staff and observed this. The registered manager told us, "Staff treat people kindly and I listen, I talk to people one to one if they want to talk to me, I work alongside the staff as I like to see what they are doing." The service operated a key worker system, each person was allocated a specific staff member who would ensure they received care in line with their care plan and had everything they needed. One health and social care professional told us "I feel the respite service is very person-centred in their approach to support and the care planning and a few of the staff have known some people for years."

We saw staff responded to people in positive ways offering choice and respecting their decisions. A health and social care professional told us, "I do feel that the staff have a good understanding of equality, diversity and have respect for people's differences."

The needs of some people required a lot of staff support but where people were able to retain their independence, this was encouraged by staff. One person using the service used a wheelchair but was able to walk short distances when supported by staff. We saw staff regularly walking with this person and supporting them appropriately at a pace that suited the person. A health and social care professional commented, "Bradbury Manor get to know the residents they work with very well, usually if there is a planned timeframe for someone coming in, the service user will have visits for tea etc before coming into stay and short stays may be offered to start with. Staff do have a good knowledge of the residents but they

also recognise if they aren't able to meet the needs of a person and will contact the necessary people and act accordingly."

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan in place which contained details of their care needs, things that were important to them and people they were close too. Personal profiles enabled staff to gain information at a quick glance to refresh and aid their understanding of that person. At times there was a lack of information recorded which staff were aware of in discussion but not documented in care plans. For example, one person would wear a protector pad on their person but there was no information about why they needed this or how to manage this for staff to be aware. Another's person's care plan documented they needed staff supervision in all aspects of personal care, but not by how many staff or how staff were to support during this time. Daily records were clear, however they focused on tasks that had been completed rather than what people had enjoyed and achieved that particular day.

The terminology in care plans and daily records was not always appropriate for the young adults that were being supported. For example, we saw statements documented including "[name of medicine] on body" and "[name of person] very slow and lazy did a fake seizure from the minute they got up and asked for sweets. I did not give any as behaviour was so much this morning." There was a concern that staff could be treating people as children from this recording, however we did not see evidence of this in practice. We have fed this back to the registered manager to address.

People had information recorded relating to their communication needs, however this did not always contain enough detail especially for the high numbers of agency staff that worked in the service. For example, one person's care plan stated "[name of person] uses a few words and can understand most of what people say." This did not explore what these words were or meant to the person and what staff could do to support this person's communication and understanding. We spoke with the registered manager about The Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. The registered manager confirmed they were aware of this term but had not read about it yet.

We saw that people received an annual review of their care and support needs, or if there were any changes in between. Care plans that we viewed contained an amendment form so changes could be recorded for staff to be aware of. One health and social care professional told us "When I have reviewed care plans and risk assessments as part of my clients review and made recommendations or asked for things to be reviewed or amended, these have always been acted upon."

The service did not have information recorded about how people wished to be cared for if they became unwell or in the end stages of their life. This was especially relevant for some people who were at risk of sudden death and had no information available on their preferences for being supported. The registered manager told us this would be addressed.

Staff were observed communicating effectively during their shifts with each other. A handover would take place between the shift leads and a handover form recorded information including medicines, daily notes,

night checks and ensuring shifts were covered. Staff spoke positively about organisation in the service commenting, "Shifts are well organised" and "Communication is good in the team, we get a good handover."

The activities offered at Bradbury were based on a flexible timetable. This was dependent on who was staying at the service on any given day, if they attended a day service and what was suited to individual need and preferences. Group activities did take place and were planned throughout the year. These would then be offered to people in advance so they could decide if they wanted to attend. One relative told us "[name of person] enjoys going out, they have gone out on a few trips." Staff commented, "It can be difficult with activities because of the range of needs to meet this. The service does take people out, but there is no fixed timetable" and "We have a minibus and can go out, quite a few staff are able to drive. During the year we plan some trips and it takes a lot of planning, but we see who is in, we have to be quite flexible with different people."

We observed staff spending time with people and encouraging engagement in activities. One person was completing a jigsaw and a staff member sat down with the person and showed them a way of finding pieces more easily. Health and social care professionals commented, "They offer a range of activities to suit individual needs" and "Staff are excellent at making the service users feel included in all activities, however, they are also aware of each individual's abilities, therefore, ensuring that nobody is asked to participate in something that staff know they will fail in."

Although we observed sensory stimuli around the home, staff commented that it would be good to have more around to meet the types of people's needs coming into the service. A staff member said, "The sensory room got taken over as an office, I did use this with people previously." One health and social care professional commented, "I think the service would be improved with a sensory room. A lot of clients are on the autistic spectrum and have sensory integration needs, and would gain a lot from a quiet area that could be manipulated in terms of lighting, activities and sound." We fed this back to the county manager who told us they had also been thinking along similar lines to this.

People had information available to know how to make a complaint or raise a concern should they wish to do so. We reviewed the complaints log and saw that whilst complaints were logged, there was very little information on how it had been managed or followed up to see if the complainant was satisfied with the actions taken. The registered manager reassured us that whilst this was done in practice, they did need to document the action taken more clearly. One health and social care professional told us, "I feel that the manager and staff are approachable and have always felt that Bradbury Manor is a warm and friendly service, staff will stop, chat and share a joke with services users, families/carers and professional's alike, remaining professional at all times. If concerns are raised, they are dealt with efficiently and effectively, with managers/staff seeking appropriate advice if necessary." We saw compliment cards displayed on the noticeboard so staff could also share in the positive feedback received.

Requires Improvement

Is the service well-led?

Our findings

Services are required by law to send us statutory notifications about incidents and events that have occurred at the service and which may need further investigation. Leading up to this inspection the provider had delayed notifying us of two incidents of unsafe medicine practice and an allegation of abuse. The provider had to be reminded to send these notifications without delay.

At this inspection we found that the provider had further failed to notify us of two allegations of psychological abuse occurring in April and May 2018. Three incidents of physical abuse had also not been notified, although the safeguarding team had been made aware.

The registered manager told us on some occasions they had been off and was unaware that the notification had not been made. The registered manager confirmed all staff were knowledgeable on how to make notifications in their absence. We saw that in some instances the appropriate action or measures to reduce the ongoing risk had not been investigated or taken. The registered manager was unable to tell us the outcomes or confirm that an investigation had taken place in these instances. There was no documented evidence that it had either. This meant people had been left at risk of ongoing harm.

The registered manager told us, "We didn't think about the incidents always as abuse, we reported to safeguarding and just went with along with that." The county manager was disappointed and apologetic that these incidents had not been reported appropriately and addressed this with staff during our inspection, commenting, "I don't want people to be scared to report, it's about being open and contacting all the relevant health professionals." We have asked the registered manager to check all incidents within the service for this year and report without further delay any further incidents that are notifiable to The CQC and to the safeguarding team. Since our inspection the incident from 2017 has now been notified but the others are still outstanding.

This was a breach of Regulation 18 (2) (e) Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

The provider's quality assurance systems in place had failed to identify concerns in the service for timely action to be taken, to keep people safe. The quality tool did not consider all aspects within the service that should be checked to ensure the service people received was effective and safe. This meant there was a lack of provider oversight of events happening in the service and action to address this. We found that concerns around medicine management, incidents and investigations had not been identified prior to our inspection. The registered manager told us, "The quality assurance process is not robust enough."

We saw that one medicine audit had been completed this year. The registered manager felt they were unable to do a medicine audit more than yearly due to their workload commitments. However, despite the service experiencing several medicines errors this had not been increased. The county manager told us that an internal quality audit and action plan had been completed in June 2018 and this identified that monthly medicine audits should be completed. However, this had not been followed. The county manager said going

forward this would be done by the registered manager and checked.

There was a lack of evidence of investigations into accidents and incidents, or measures that had been taken in response to these. Information was detailed in people's care plans but this did not evidence if any actions had been taken or how this would be prevented going forward. The county manager told us that staff needed training around what is classed as an incident. They were meeting with the new trainer to discuss meeting the needs of staff in areas such as this.

Although we were informed that care plans were checked as part of the quality assurance system the registered manager confirmed this was not recorded on what had been checked and what changes had taken place as a result. A care plan audit had last been checked in July 2018 however, the registered manager said actions and timeframes had not been set due to being so short staffed and busy. This meant there was a lack of improvement action identified and addressed within the service to ensure people received a good quality service.

Policies in the service were not always in place and the one's we reviewed did not offer enough guidance for staff. We reviewed the safeguarding policy for the service which was dated March 2017. It had been reviewed in January 2018 but staff confirmed the updated copy had not yet been sent and was not available in the service. The policy in place was for Wiltshire adult's safeguarding board, but was not personalised to this service or the staff using it. The policy did not consider what training staff should have undertaken, or what they should to do after reporting at a local level within the service, or how to investigate and record. The county manager told us they would look into this.

We were unable to review some of the other policies as the service did not have them in place, this included a policy for incidents and accidents and a policy around mental capacity. The registered manager informed us they had tried to look for one around capacity and raised this higher up already but had not been given one yet. Since our last inspection the staff had put together a challenging behaviour policy in house that they could use to provide guidance.

This was a breach of Regulation 17 (1) (2) (a) (b) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The last inspection report was displayed on the provider website, although this is hard to locate due to the wealth of information and services available on The Wiltshire Council website. We saw the report was displayed at the location, however this in the front entrance behind a key padded door and not accessible at all times for people in the service.

A registered manager was in post at this service and was available throughout our inspection. Staff we spoke with told us they felt well supported by the registered manager and able to talk to them if needed. One staff member told us, "I have seen good management and they manage the shifts well when staff are off, or for people who have complex needs. I would go to the manager, I have confidence in them." The registered manager was visible in the service and worked alongside other staff. One relative we spoke with said, "I see the manager, they are accessible."

Health and social care professionals told us they felt the manager worked well with them and was available when needed commenting, "I feel I have an excellent relationship with the staff and managers at Bradbury Manor, based on openness, transparency and sharing of pertinent information" and "I have always had a very good relationship with managers and staff, always a senior member of staff available to speak to in the absence of the manager, or they will seek the most appropriate person to speak to who would have the best

knowledge of an individual."

We saw that staff attended team meetings with the registered manager and that the minutes of these were documented. The registered manager told us they felt supported by senior management and commented, "I feel well supported; the county manager has knowledge and grass roots of respite, he understands. Respite is hard as we have so many changing faces who come through."

The service sent out feedback questionnaires to people and their relatives each year to assess their experience of the service. The registered manager told us that historically they did not always receive many back. Although the responses were considered, there was no action plan from this used to improve the service and the results were not displayed or shared with people other than verbally. One relative told us it would be nice to receive more communication from the service in-between their family member staying, such as a newsletter to update on any changes.

The registered manager spoke about the work they had been doing since the last inspection and the improvements made around mental capacity assessments commenting, "We have made improvements, mental capacity assessments are more knowledge based now, there has been investment in training and time given to administration. People feel supported, I feel supported by my team. It will also be a great achievement to get some of the decorating works done." The service had experienced some setbacks when they lost their online files at the start of the year and had to spend time addressing this loss. One staff member told us they were committed to getting it right stating, "Anything we need to action we will put in place immediately, we will keep on working and improving." One health and social care professional commented, "I feel the service are doing everything to the best of their ability, with the constant changes in regulations and paperwork. I feel the team strive to ensure that they have all the correct documentations in place whilst remaining positive and keeping Bradbury Manor a place where people want to return to."

The management and staff valued the importance of maintaining partnerships and links with external professionals and would work alongside them to meet people's needs. We received positive feedback about this service. One health and social care professional told us, "I have never had any concerns, the service are very good at contacting myself and our team with any queries or concerns and are happy to share information where allowed. I personally feel that I have a good working relationship with all the staff working at Bradbury Manor." The registered manager was also part of 'Bradbury friends', a group championing and fundraising to support the service. The registered manager had been part of fundraising events and people had enjoyed a trip to the theatre through this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of allegations of abuse within the service. Regulation 18 (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that notifications of a safeguarding nature had not always made to The Care Quality Commission. Further to this evidence of the service's investigations into events were not always recorded, or actions taken and documented, to ensure risks were minimised and people were kept safe. There were no records of the room temperature to show that medicines were being stored at appropriate temperatures. Regulation 12 (2) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems in place had failed to identify concerns in the service for timely action to be taken, to keep people safe. There was a lack of evidence of investigations

into accidents and incidents, or measures that had been taken in response to these.

Regulation 17 (1) (2) (a) (b).