Wiltshire Council

Bradbury House

Inspection report

The Portway
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bradbury House provides planned and emergency short term respite care for up to ten people with a learning disability, some of whom may have additional physical care needs. All accommodation is on the ground floor and in single rooms. There are shared recreational rooms and accessible gardens.

The service did not always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence

The service was bigger than most domestic style properties. It was registered for the support of up to 10 people. The size of the service having a negative impact on people was mitigated by the building design which included wide corridors and level access for people with mobility needs.

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

Risks were not well managed and placed people at potential harm. Risks were not consistently assessed and action plans developed on minimising the identified risk. Where people sustained injuries there were not investigated. This meant staff were not given clear guidance on the measures to reduce the risk.

People were placed at potential risk of harm.

Safeguarding procedures were not followed. This was despite the staff having a good understanding of safeguarding people from abuse and having these procedures on display for reference. Some safeguarding referrals had been made in response to relative's concerns, but safeguarding referrals were not made for all abuse allegations.

Accidents and incidents were not well managed. This meant trends were not identified and there was little evidence of learning from these events. Organisational policies and procedures such as risk assessments were not always followed. CQC was not notified of all reportable events.

The staff told they "now" felt confident to report poor practice and that their concerns would be taken seriously.

National recognised induction programme was not followed for new staff. . For some staff the induction covered reading care plans and touring the property. The manager has taken steps to ensure the most recently employed staff complete inductions that meet Skills for Care standards. Some staff were assisting with behaviours deemed to be challenging when they had not attended the appropriate training.

The training matrix was not accurate and up to date. The names of staff on the training matrix did not

correspond with the names on the staff rota. This meant there was a lack of monitoring on the training staff had attended.

One to one staff supervision meetings with their line manager were not regular although action was taken to address this.

People were not fully supported to have maximum choice and control of their lives. Staff did not support people in the least restrictive way possible and in their best interests.

Mental capacity assessments were in place for some decisions. Where people lacked capacity there were some best interest decisions to impose restrictions through the deprivation of liberty safeguards (DoLS) process. Applications for DoLS were in place for some people that had one to one or two to one support. However, capacity assessments were not in place for all the people that were having this support. This meant steps were not taken to ensure this was the least restrictive action.

People were not able to leave the home independently as there were entry door systems in operation. The staff told us the people using respite care were always accompanied in the community. DoLS were not in place for all the people that had their liberty restricted. Where DoLS applications were in progress they were not reviewed to ensure the restrictions were appropriate.

While staff said the team was "fractured", they said the leadership had improved. The culture and practice was not always consistent with the organisations values of team working, responsibility and leadership. Staff told us there were groups of staff that liked to only work with specific staff. The head of services and managers had taken action to address staffing issues which included changes in shift patterns. The head of care and manager said team building was to be organised.

The registered manager was on a period of absence from the home. An interim manager had been appointed to cover this leave. While the manager had only recently been appointed they had an oversight of the improvements needed.

The recently appointed manager was organising audits to develop an improvement plan. This included areas such as equipment, training, risk assessments and fire safety. The manager told us communication and role modelling were areas being developed. Staff were to be assigned with lead roles, which enabled staff a central point of contact, if they needed advice.

The manager was taking action to ensure staff were following procedures to support improvements and there was to be input from external professionals.

Recruitment processes had been properly followed.

Rating at last inspection
The last rating for this service was Good (published on 17 April 2019).

Why we inspected
We received concerns in relation to the safety of people at risk. As a result, we undertook a focused inspection to review the Key Questions of Safe, Effective and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key

Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bradbury House on our website at www.cqc.org.uk.

Follow up
We requested weekly action plans for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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.
Details are in our safe findings below

Is the service effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-Led findings below

Bradbury House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector

Service and service type
Bradbury House is a 'care home' providing respite and emergency 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was on an extended period of absence. A manager is currently covering the registered managers absence.

Notice of inspection
This inspection took place on 1 and 2 July 2019 and was announced on the second day.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We spoke observed the interaction between staff and people. We spent time with one person and two staff in the sensory room. We spoke with eight members of staff. We also spoke the manager and head of service.

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

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding procedures were on display within the home and comments from staff showed they had a good understanding on how to apply safeguarding procedures. However, procedures were not followed. [.

●A safeguarding referral to the local authority was not made when one person made allegations about a member of staff. Instead a meeting was held with the person with three other staff and in the presence of the staff referred to in the allegations. At the meeting, this person was asked to account for the claims made about the staff member. The recently appointed senior told us action to calm the situation was taken at the time. Subsequently we saw advise was sought on making a safeguarding referral

● Body maps were used to illustrate where on the body injuries such lesions, or wounds were noted. We noted when staff had observed bruising, the cause of the unexplained injuries were not investigated. The follow up action was not always documented and the staff we asked were unsure what, if any actions had been taken.

People were placed at risk of harm due to poor safeguarding procedures. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The manager was working with the local authority safeguarding team in relation to abuse allegations they had raised. An action plan was devised and the head of care, as well as other professionals were working towards ensuring people's safety.

Assessing risk, safety monitoring and management

●Risks were not well managed. A member of staff said, "care plans and risk assessments are repetitive, but they are not up to date. They are not reviewed when there are changes".

● Incidents were not well managed. Guidance was not developed although a care manager had advised the staff at the home to develop risk assessments on visiting regimes. We saw documentation where the care managers had instructed staff to develop risk assessments. However, risk assessments on how staff were to manage these situations were not devised or reviewed following each incident. Staff said they were, " just told not to let the [name] into the building. Two staff said they "don't know what she looks like" and "I would call the police". This meant people and others were placed at risk of harm.

●There were three incidents documented where there were confrontations with a visitor and on one occasion police intervention was needed. On another occasion at an external event, the home was contacted for guidance on the actions to take when they were challenged by the same member of the public.

●People were not supported by skilled staff when they expressed their emotions and frustrations using

behaviours deemed to be challenging. A member of staff said that they "chose" not to work with specific people unless male staff were on duty. Another member of staff said, "I've not had positive behaviour management training and I assist with managing these incidents." The head of care told us following the inspection at the team meeting, there were discussions about having male staff on duty on each shift. They said, "if there are concerns with challenging behaviour there will be support from strategies and additional training."

● The care assessment dated July 2018 stated that one person at times "struggles with aspects of their behaviour." The statements from the care assessment were copied onto "how best to support me" and the "about me" documents but not expanded on to give more detail. Although staff were directed by the care manager to devise risk assessments, guidance was not expanded or developed. The diary sheet confirmed that on the 8, 9 and 10 June this person showed signs of anxiety and had made allegations of self- harm. However, a plan on how staff were to manage these behaviours was not in place. This meant staff were not given guidance on how to manage situations in a consistent manner.

●Safe moving and handling procedures were not followed, which meant people were not appropriately supported with their mobility needs. At the team meeting dated 15/05/2019 a member of staff raised that there were changes with people's mobility. They said one person needed hoisting because they were not able to weight bear. However, risk assessments were not devised or reviewed for these individuals.

●A member of staff said they had attended moving and handling training but were not shown how to use the equipment people were using. This member of staff said, "we were told to read the care plan". This member of staff said "there is conflicting information from different staff on how to transfer. For example, using the hoist but also guiding the person because they were able to weight bear. Another member of staff said "we have equipment and we were shown how to use the equipment. People have their own slings to use with equipment. Risk assessments are not always in place, I flagged it up."

●The manager said they had contacted the occupational therapists (OT) and asked about the aids and equipment people used. A meeting was to be scheduled to organise the training needed by staff to assist people with moving safely.

Learning lessons when things go wrong

● Accidents and incidents were not well managed. Organisational accidents and incidents procedures were not adhered to by the staff. Staff were not clear on their responsibilities to report accidents and incidents. This meant events were not assessed, monitored and themes identified.

● Accidents and incidents were not always reported or investigated according to the procedure. Comments from staff confirmed there was little discussions following accidents and incidents. Staff said seniors completed incident reports from the recorded information in daily reports.

●The staff said there was no debrief following accidents and incidents. A member of staff said, "We leave the daily reports for the senior who will deal with the incident when they are on duty. The incident may be brought up at the next team meeting." Another member of staff said "There are no debrief. You are told to write the report and you don't hear anything after that. Incidents go to the senior or the manager." Another member of staff said "Incidents are discussed at team meetings. You go back and read the care plan. I go through the care plans when people first arrive. There is no debrief following accidents and incidents." The manager told us the staff were to be given instructions to complete corporate accident and incidents forms. The lack of discussion meant there was little learning from events.

● Accidents and incidents were not consistently reported. A new member of staff described an incident that occurred in the community. This member of staff told us they were instructed to accompany one person on an outing although they did not feel confident. They said they were approached by a visitor with strict guideline of visiting. This member of staff said they were "thinking on my feet. I kept [name] at a distance. I didn't sit close to [name] in the bus". This member of staff said they did not documents the incident. The head of service and manager told us after the inspection the risk assessment was now in place. This meant

clear guidance on the actions to take was not reviewed or patterns identified when there was a risk of potential harm.

People at risk of harm due to poor management of risk. Systems were not robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The deployment of staff was reviewed to ensure the staffing levels met the needs of people having respite care. The manager was assessing current staffing levels. Staff told us there were inconsistencies with the deployment of staff. A member of staff said the rotas had improved since changes. This member of staff said they were not rostered when people were not at the home. Another member of staff said, "There are times when there are too many staff with few people and vice a versa its touch and go".

●Recruitment procedures were well managed.

Using medicines safely

● The staff attended medicine management training to ensure their competency with administering medicines

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

●People's needs were assessed by the care coordinator before respite care was agreed. Some care plans were devised on how to meet people's needs but action plans lacked detail. [on how to meet needs identified.]

●Good practice guidance and legislations was not always followed. Duty of Candour and Safeguarding procedures were not consistently followed. The staff had failed to investigate incident and accidents and notify appropriate agencies. Staff were not always honest to relatives on the injuries sustained. This meant a transparent culture was not promoted. The head of services and the manager told us this related to only one incident and they have apologised to relatives for the miscommunication.

● While there were some open communications between staff, relatives and external agencies, partnership working was not always consistent. Where recommendations were made to develop risk assessments these were not developed.

Staff support: induction, training, skills and experience

● At the inspection dated 22 May 2019 we recommended the service found out more about in-house training for new staff which was based on current best practice. However, this recommendation was not followed because new staff were not having an induction that met national guidance.

●New staff did not receive an induction to prepare them for the role they were to perform. A member of staff told us they had experience of working in care environments, but this was their first experience of respite care. This member of staff said "I had a tour of the building and that was it. I was on duty from 9:30am. I got given care plans and that was it. Online courses, we just got told the website and the list of courses to complete. I feel confident to work here and that is because of my previous experience, nothing to do with the training here."

● There was no evidence of two new staff having had an induction. We spoke with a new member of staff, who told us they had an induction on the first few days. They said they had shadowed other staff and were waiting for logging details for online training. The comments of the staff were not documented.

● The organisation had set the mandatory training the staff must attend. The training matrix listed the names of the staff and the training attended. We noted some training was due and the names of staff in the rota were not the same as in the training matrix. This meant some staff had not attended the training needed to support people at the home. For example, positive behaviour management.

● Records showed one to one staff supervision sessions with their line manager were not regular. Some staff said they had supervision while others said there were "various team meetings and the registered manager

told them, "my door is always open". Another member of staff said "I had supervision with [senior] every couple of months, I can talk to [senior] at any time. I ask for one if I need it." The manager was following the action plan devised for all staff to have one to one supervision.

●The manager said an audit of staff training was to take place and a request was made to the training section for new staff to register onto the Care Certificate (agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors). Probation meetings for new staff were introduced and would take place during induction. The staff were to be issued with laptops to undertake mandatory training. The manager told us positive behaviour training was to be organised. We recommended that if staff had not attended positive behaviour training, they should not assist with incidents deemed to be challenging.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

● The principles of the MCA were not consistently followed. Although the staff were knowledgeable about MCA principles of people having choices, restrictions were imposed on people's freedom, without the legal authority.

● Mental capacity assessments were in place for some specific decisions and DoLS applications were made from best interest decisions where people lacked capacity. However, capacity assessments were not completed for all specific decisions. Some people were having one to one support and at times two to one staff support throughout the day and night. Capacity assessments were not completed to ensure this was the least restrictive action.

● We saw a statement from a member of staff about an incident, where staff made the decision to restrict one person's access to the dining room. It was evident from the statement that the staff were not clear on the actions to take when incidents of this nature occurred. The information or other records did not show who made the decision to restrict access into the dining room. A member of staff said another member was assigned to complete an application to gain authority to restrict access into the dining room. However, applications were not reviewed to ensure they were accurate and up to date. This meant staff had not ensured care was delivered in the least restrictive manner.

● On the second day of the inspection the staff were being supported to complete DoLS applications.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Organisational policies and procedures were not being adhered to. There was no documented evidence that staff had read them or that processes were being followed. For example, safeguarding of people at risk, accident and incidents and positive behaviour management procedures.

● An audit on the quality of service delivery was undertaken by an external company.The head of services told us there were two visits which included the assessment and follow-up to re-assess outcomes. At the second visit this company gave the home a good rating. However, the findings were not consistent with this inspection.
● The registered providers were not notifying us about events and incidents that affected the service or people. Where safeguarding referrals were raised, we were not kept notified of these events. We were not notified of incidents reportable under Regulation 18 Care Quality Commission (Registration Regulations 2009.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was on a period of absence from the home. A manager was covering the registered manager's post during their absence.
● The manager was recently appointed and they had an oversight on the improvements needed. This manager was organising audits to develop an improvement plan. For example, equipment, training, risk assessments and fire safety. The manager told us communication and role modelling were areas being developed. Staff were to be assigned with lead roles which gave others a central point of contact for advice if needed

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
● The values of the organisation were on display within the home. The staff knew the values of the organisation which included trust and respect, simplicity, responsibility, leadership, working together and

excellence. Although staff said they "came together when necessary, for the good of people" the culture and practice was not always consistent with the organisation's values of team working, responsibility and leadership. A member of staff said, "most of the time [I] would work within the values of the organisation". This member of staff said that not having a full team and not working together impacted on staff's abilities to practice the values.

●Staff told us "everyone is quite set in their own groups. They pull together when needed but stick to their own groups. Can be intimidated which has been mentioned in meetings." This member of staff said there were changes and these groups had been split. It was stated "[We] are now working different shift patterns. Some staff are struggling with the changes. Things have been a certain way for a long time. There are always whispers you have to watch your back a bit. Staff became lazy, it was the bare minimum and that was good for them."

●Another member of staff said, "the team is fractured, there are splits in the team." They said, "the relationships between staff could be improved with team building. It's a long running issue. Recent changes have brought staff together better. "

● The head of services and manager took action to address staffing issues. There was better management of staff rotas which included changes in the deployment of staff and team building was to be organised. A member of staff said the changes in the deployment of staff was positive. They said staff were no longer on duty when people were not at the home and were participating in community day services.

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

● The feedback from people was gathered through monthly resident's meetings. All meetings were based on activities and their satisfaction with the service. People were positive about the service. The template used to document the agreements from the meeting, was in pictures and words.

● One to one supervisions and team meetings were used by managers to give staff feedback on their performance and actions they must take. At the staff meeting in May 2019, staff were reminded about training, housekeeping and Health and Safety procedures. There was an expectation that staff read and signed documents to show they agreed with the decisions made at the meeting. We noted that only five staff had read the copies of the meeting.

●No complaints had been received at the home since February 2018. The last complaint referred to booking availability.

Continuous learning and improving care; Working in partnership with others

● The manager told us the corporate online system of reporting accidents and incidents was introduced to identify patterns and trends.

●The manager told us of the priorities for improving the service. This included integrated working. For example, a senior from day services was to support the manager to support role modelling. Communication was to be developed which included how staff accessed information in the right format. There was to be regular team meetings and one to one supervision sessions. The manager reviewed staff handover documents and approved the rota to ensure staffing issues and team building was monitored.

● New staff were to be assigned mentors and complete a comprehensive induction, with regular probation meetings.

● Phones were to be provided for staff when they took people out. Records of outings were to be maintained which included the name of the person, the destination of the outing and the times of return.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not well managed. Risks were not assessed and action plans were not developed on how to minimise the risk. Where people used behaviours to show their anxiety and frustrations. Action plans were not devised on how to manage these behaviours. All staff managing behaviours were not always trained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding referrals were not made for all abuse allegations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The CQC was not notified of all incidents and accidents. Audits had not identified all the shortfalls found at this inspection.