Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Bradbury House

The Portway, Salisbury, SP4 6BT

Tel: 01722349144

Date of Inspection: 24 January 2013

Date of Publication: March 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Wiltshire Council
Registered Managers	Miss Jemma Dowdney Ms. Susan Gray
Overview of 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.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 24 January 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

What people told us and what we found

People stayed at the home for short breaks. Most people used the home regularly for respite. Some people stayed because they needed an emergency situation to be resolved. People brought personal items with them for their stay. If necessary, they could occupy the same room each time they came, so it would be familiar. A person staying at the home said staff helped them settle at the home and were always available.

There was a games room with a pool table and other games and pastimes. People were supported to keep going to their usual day facilities, employment or schools. At weekends they had trips out. We saw the staffing level was varied to suit the support needs and activities of people staying at the home at any time.

Staff were friendly and respectful to people. They had guidance on meeting people's communication needs and we saw they were skilled in communicating with people. One person told us "I don't like crowds; staff understand that."

Support plans gave staff detailed guidance about people's care needs, including how to use any equipment. A person staying at the home told us "I have epilepsy. The staff know what to do when I have a seizure." However, some records were not helpful because they did not show how old information was or if it came from Bradbury House.

There were safe arrangements for keeping people's money if they wished. Staff were trained in recognising if people might be at risk, and what to do if they had concerns for people's safety.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 14 March 2013, setting out the action

they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

The service provided short break accommodation with care, mainly to people who stayed there regularly. Two of the places in the home were available for people in need of short term accommodation and support as a result of emergency situations. In that case, people could stay for several months whilst plans were made for their longer term needs.

Some of the people that stayed regularly liked to use the same room every time, or needed to do so because of their individual needs. We were told admissions were planned around these requirements. People were encouraged to bring personal items with them for their stay. Rooms we saw showed that people were able to make themselves at home, even for a few days. A person who had been staying regularly at the home for a long time told us they knew all the staff well, which made it easy to settle each time.

For some people who stayed regularly at the home, family carers chose to maintain communication books between themselves and home staff. This meant they kept each other up to date with significant changes, so people received continuity of care. We saw the home used shared diaries to communicate with schools and day facilities that people attended. Staff made 'courtesy calls' to families after people had returned home from respite stays. These were to give family carers the chance to express any comments on how the service had met their relative's needs. Where families had indicated they did not wish for contact after every visit, this was respected.

Care records showed that families were invited to give information about people's preferred routines, likes and dislikes at home. This was used so the service could ensure people received care and support in ways that were meaningful to them. There were preference assessments for each person using the service. These went into detail, for example noting how many pillows a person used and how much ambient light they liked at night. The detail about people's likes and dislikes showed that considerable time had been spent on recognising and providing for individual needs.

Some information about people was summarised in useful one page profiles. The provider may find it useful to note, however, that once completed, this kind of information showed little evidence of being updated. For example, a person showed us they spent a lot of time colouring as a favourite activity. We saw a member of staff showing an active and obviously familiar interest in this, but it did not figure in the person's recorded likes and interests. There was some use of person centred care planning tools. These gave insight into what was important to people, but had not yet been used greatly to influence how care plans were written.

People referred for respite stays were invited for teatime visits before actually staying overnight, sometimes on several occasions until they felt confident to stay. While staying at the home, people were given the choice whether they wished to have a key to lock their bedroom door. A person staying at the home showed us their room. They told us they locked their room whenever they were not in it. They said staff never entered their room without asking and being invited in.

We saw people chose to use different parts of the home during the day, so they could enjoy privacy or company as they wished. One person told us "I don't like crowds, staff understand that." There was a games room, which featured a pool table, age appropriate games and DVDs. A person told us about support they received to attend both a voluntary and a paid job, and to go out for leisure. They said staff helped them settle at the home and were always available to talk to and do things with. Another person said "I like doing girlie things." We saw them being supported to look at a fashion magazine. They spent time with a member of staff in a training kitchen, making a jelly they were to share with friends at teatime.

We saw that staff were skilled in communicating with people, verbally and non-verbally. All interactions we observed between staff and people staying at the home were friendly and respectful. Some people staying at the home were unable to communicate verbally. Support plans included guidance on meeting people's communication needs. We saw from training records that staff received training in promotion of dignity and maintaining positive relationships.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Most people were supported to access services from their usual GP surgeries so they experienced continuity of health care. People staying for longer emergency placements were registered as temporary patients with local surgeries. The home also made use of a local walk-in medical centre, if people needed urgent medical attention whilst staying in the home. We saw a person had sustained a finger injury. This was recorded by way of a body map and there was a full record of support given before, through and after a visit to accident and emergency. Staff told us a member of staff always accompanied any person through a hospital visit to provide reassurance and assist communication with health professionals.

In all care plans there was a standard form for passing on important information to other care providers, for example if someone needed to be admitted to hospital. Team leaders told us they were developing 'grab and go' forms to accompany people on any trip out from the home. These would be accompanied by a photocopy of the current day's medicine administration record for the person.

Some people who stayed at the home had complex physical care needs. Support plans contained detailed information to guide staff on providing care and support in a way that met individual needs and preferences. For example, one person had a posture management plan, which included photographs to promote consistency of approach. This was developed with an occupational therapist. Copies were kept by the person's bed and with their wheelchair. The plan included ensuring regular changes of position by day and night. Staff completed charts to confirm care was given as directed. Senior staff checked these records. Staff kept factual records of how people spent their time and how care and support were provided.

Some people used mobility equipment, such as hoists. There was pictorial guidance for staff to follow, to ensure equipment was used safely and comfortably. We saw examples of nutritional guidance based on health professionals' information, and of epilepsy profiles with management protocols, where applicable. There was evidence staff were active in seeking reviews of these and other externally produced assessments before they became out of date. A person staying at the home told us "I have epilepsy. The staff know what to do when I have a seizure." Staff had been trained in administration of recovery medicines.

Staff we spoke with said they felt well informed about the people supported by the home. A support worker said they were given assessment information about people before they were placed at the home. They had opportunities within their working time to read care plans. Staff told us they received full handovers of information between shifts. They were directed to read changes that had been made to care plans.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People were given a choice about whether to keep spending money on their person or to have it looked after during their stay. We saw there were safe arrangements for keeping people's money. People could access their money at any time. The provider's regular audits included checking that correct processes were followed in supporting people to manage their money. Two people staying at the home told us they needed staff to help them look after their money. They said they felt safe in the home and only went out with staff support. They said they were often reminded that they could go to any staff member if they were worried about anything.

All staff had received training in abuse awareness and safeguarding procedures. This was mostly by way of computer-based or e-learning. We saw that the training included reference to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The manager had attended specific manager's safeguarding training. The provider ensured there was an on call manager available to be contacted at any time, so staff would always have managerial guidance in referring a concern to the local authority safeguarding team.

There was experience in the home of admitting and supporting people in circumstances where they had been subject of abuse or risk of abuse elsewhere. Staff described the support needs of a person currently using the service, which had been referred for specialist DoLS advice.

Staff were clear with us about the meaning and importance of whistle blowing. They had confidence that any concerns they might raise would be treated seriously and progressed through appropriate channels. We have seen that where a staff member raised a concern in this way, the provider investigated the matter and took disciplinary action in response to what they found.

Where people could display behaviours that others could find difficult, support plans described these. They identified situations that increased the risk of occurrence and known ways of reducing risk to individuals and others in the home. Staff we spoke with said they felt supported by behaviour management guidance. One person was being supported by

two staff in order to reduce their risks. The provider may find it useful to note that where a person was recorded as having displayed self harm, a full risk assessment had not been undertaken to address this specific risk.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

Staff told us, and staffing records showed, that the level of staffing provision was varied according to the needs of people who stayed in the home, and activities people had indicated they wished to undertake. For example, there could be a high number of people who required one-to-one support. Some care tasks required two staff to assist, for example with transfer by hoist between wheelchair and bed. At night, the number of staff on waking duty and sleeping in on call was adjusted according to the degree of monitoring necessary for the people staying at the time.

There was some reliance on Wiltshire Council relief bank staff for achieving the necessary numbers of staff required to be on duty. Permanent staff we spoke with were all agreed these staff worked as part of the overall team and fitted in well. They told us the relief bank was able to supply staff from a pool of eight, all of whom were very familiar with working at the home. Recent inspection of another Wiltshire Council service showed us that the relief bank provided its staff with induction, ongoing training arrangements and regular supervision.

Staff handed over information from one shift to another, so there was continuity of care and support for the people staying at the home. It was the responsibility of senior carers to prepare a shift plan in advance, so it was clear which staff were available and who they would be principally supporting. Staff we spoke with said there were sufficient staff to allow appropriate working with people who could present difficult behaviours.

We saw during our visit that staff maintained awareness of people's support requirements. They spent their time directly supporting people, or being close at hand if attending to tasks such as food preparation. People's care and support needs were attended to promptly, so people did not become uncomfortable or agitated through awaiting staff availability.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Records showed staff received individual supervision from the manager or team leaders at intervals of six to eight weeks. Supervision meetings were recorded in a consistent way. Staff told us the manager and team leaders were also readily available for meeting informally about any issues arising. Staff received annual appraisals.

Training records showed staff received training relevant to the needs presented by people that stayed at the home. For example, there were records of training in autism awareness, dementia, epilepsy awareness, and positive behaviour management. This was in addition to regular mandatory refresher training in core skills such as first aid, fire safety and moving and handling. Records showed staff were in date for such training, or that refresher training was arranged.

We saw that staff were supported to attain relevant qualifications, formerly National Vocational Qualifications, now Diploma in Social Care. A specialist trainer had been engaged to train staff in supporting a person fed through a tube into their stomach. All staff received annual training and competency assessment in handling medicines.

We asked about the integration of workers new to the home. Team leaders told us new staff shadowed experienced members of staff for at least a week before being put on the rota as part of the staff team. We saw there was an induction record that temporary members of staff went through before they began working with people in the home. They were given specific time for reading policies, care plans and other records. They received weekly supervision during their probationary period. A permanent member of staff who had been away for a significant time was required to undergo a re-induction.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

We saw evidence of quarterly audit visits by the provider. Where these identified any shortfalls, the manager was required to produce an improvement action plan to correct them. For example, the most recent audit had identified risk assessments that required updating. The audit process acted as a check on safety measures being upheld, including review of the home's emergency plan. There were checks on fire precautions and practices, management of medicines and environmental risk assessments. The home also had an annual medicines audit carried out by an external pharmacist.

Accidents and incidents occurring in the home were monitored regularly. This process ensured there was an overview of risks and incidents arising, to assist planning to reduce further risks.

Monthly meetings were held with people who stayed at the home, for feedback on how they experienced it and what activities they might like to be provided. These had resulted in changes, such as the nature of television service provided in the communal sitting room and new meals being added to the menus. Questionnaires were sent to relatives of people using the service in October 2012. Staff thought these were used by the provider mainly to assist planning for all their learning disability services. The manager told us after our visit they intended developing a questionnaire survey specific to Bradbury House. The provider may find it useful to note that feedback opportunities for people with special communication needs were limited.

There were monthly staff meetings. Minutes showed these covered operational matters and information sharing about people using the service. A support worker told us "the service is all about consistency and excellent communication between all the team. Team meetings are very open and lead to changes." There was a daily planning meeting between the manager and senior staff on duty. Some staff had delegated responsibilities. For example, one support worker maintained oversight of housekeeping standards and another was designated fire officer.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

Shortfalls in accuracy and reliability of records meant people were not protected from unsafe or inappropriate care.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's records were kept securely. They could be accessed quickly when staff needed them to read or to add to. Support plans gave detailed guidance to staff on meeting people's needs.

Support plans were linked to risk assessments. However, some risk assessments had been written at other respite facilities run by the provider. There was no evidence they had been reviewed as still applicable at Bradbury House and some were plainly no longer relevant. We noted other examples of care and planning records, which were not signed and/or were undated. This made it impossible to tell if they originated in Bradbury House, whether they were current or when they might be due for review. The presentation of information about people in their support plans did not readily identify when they began using the service, or their primary reason for doing so.

We noted some documents were marked as awaiting further information from families or external professionals. There was not always evidence of interim guidance being put in place, based on best information available. Staff placed some reliance on the overview assessments prepared externally around the time people first used the service. These were available in each person's care record, but some examples we saw were well over a year old. The manager informed us these were reviewed externally on a three yearly basis. They were produced to guide planning for people's needs in the community, including how use of the service fitted with this. Evidence in people's care records, for example amendments to support plans after six monthly reviews or in response to observed changes, showed that some of the overview assessment information had become out of date. This meant there was a risk that staff, especially relief staff, might place different emphasis on or have different awareness of different records.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: There was not an accurate record in respect of each service user to protect them against the risk of unsafe or inappropriate care arising from a lack of proper information about them. Reg 20 (1)(a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 14 March 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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