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 April 2013

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Cleanliness and infection control	✓ Met this standard
Management of medicines	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Wiltshire Council
Registered Manager	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

We carried out this inspection to check whether Bradbury House had taken action to meet the following essential standards:

- Cleanliness and infection control
- Management of medicines
- Records

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 April 2013 and talked with staff.

What people told us and what we found

None of the people staying at the home were in when we visited. We joined a staff meeting and we spoke individually with the manager, two senior support workers, two support workers, a kitchen assistant and caretaker.

At our previous inspection in January 2013 we found some people's care records were not helpful because it was not possible to tell if information in people's records was current and accurate. The provider told us how they intended to improve their record keeping so people would not be at risk of unsafe care. At this visit we found records had been improved and were completed and maintained in a consistent way. All documents were signed and dated. Staff we spoke with were confident they and their colleagues were up to date with the content of records.

We looked at how people's medicines were managed. We found there were good systems for ensuring people's medicines were safely looked after. Written plans made sure people received their medicines in ways that met individual needs and preferences. Staff always checked with people's families or GPs if there had been any changes in prescription since their previous stay.

We looked at how the home was kept clean. All the communal rooms and areas, and bedrooms we saw, were very clean. Staff took a pride in this. The manager had systems to keep a check on cleaning being carried out to a high standard.

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

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

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

Reasons for our judgement

We looked at all the communal parts of the home including assisted bathrooms and we saw some personal rooms, including en suite toilets and showers. We found high standards of cleanliness throughout. A kitchen assistant told us they followed a cleaning schedule, which covered the kitchen, training kitchen and bathrooms. They told us bedrooms were thoroughly cleaned as soon as they were vacant, ready for the next occupant.

Support staff told us they were responsible for ensuring the cleanliness of bedrooms whilst they were occupied, including supporting people to take as much responsibility for this as they wanted. A caretaker explained their responsibilities for maintaining standards of cleaning in communal areas. This included checking the condition of fittings such as toilet seats, throughout the home. There was secure and orderly storage of chemicals. The laundry was well organised and clean, including behind the machines. The provider may find it useful to note that some switch pull cords were dirty as they were not included in routine monitoring.
The registered manager was the lead person in the home for infection control. We saw they used the Department of Health 'Code of Practice on the prevention and control of infections' as a guide to maintaining systems to maintain and monitor standards of cleanliness in the home. The home's infection control policy stated that people with current infectious conditions did not stay at the home for respite care. People on indeterminate emergency stays could, if necessary, be cared for with a transmissible infection within their rooms, as all rooms had en suite facilities and room to enjoy leisure activities.

We saw there were accessible supplies of protective gloves and aprons for staff to use and dispose of as they needed. The home was well supplied with hand washing and sanitising facilities. Staff had been trained in food hygiene. We saw examples of good food hygiene practice being followed. Refresher training in infection control was currently being arranged for all staff. We joined a staff meeting. Health and safety was a standard agenda item. Minutes from the previous meeting showed needs had been identified for new shower heads and additional laundry nets. It was confirmed these items had been

obtained and put in place. The manager had been monitoring food labelling in the fridges and said improvements had been made.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

One of the senior care staff was the lead person for medicines practice in the home. They showed us the home had safe systems for receiving, storing and managing medicines. The provider had recently updated the medicines policy.

All support staff were involved in administration of medicines. We saw evidence they received appropriate training. This was supported by regular checks on their competency. We joined a staff meeting, in which the lead person gave staff reminders about ensuring safe practice. They had just completed a quiz exercise with the whole staff group, to test their knowledge. All medicines tasks involved two members of staff, as a means of ensuring accuracy.

Each person using the service had a medicines folder, which was kept in the medicines room. We looked at three of these. They included a full list of medicines taken, with reasons and start and finish dates, so a history of a person's medicine needs could be easily seen. There was a person centred administration guide, which showed how people liked to receive their medicines. For example, one person was given medicines in their room and another preferred to do so in the dining room. There were details of which drinks or foods people favoured for helping them take medicines. Where people could not express preferences, staff had taken account of privacy and dignity issues in how guidance was written. Medicines risk assessments showed evidence of six monthly review.

The individual medicines guidance referred appropriately to people's care plans. For example, we saw a person's epilepsy management plan was included in their medicines folder. This included guidance on how to make a decision about use of rescue medication. The person's close relative had signed agreement to the protocol. For all medicines prescribed for use 'as needed' there was a protocol on file. Where an 'as needed' medicine was linked to bowel function, the relevant recording chart was kept in the medicine folder so decisions to administer were related to the most up to date information.

Staff told us any changes in a person's medicines regime were communicated through staff handovers. Actual administration was recorded in a medicines administration record (MAR). We looked at the current MARs. These were completed correctly and matched

with the information in people's medicines folders. Use of prescribed topical creams was recorded in the MARs.

There was evidence of close liaison between the home and people's families. Sometimes when people returned for a short stay their medicine directions differed from the home's record from their previous stay. In that case, firm confirmation of the latest prescription was sought either from the family or the person's GP surgery. People could not remain at the home without this verification having been recorded.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

When we previously visited Bradbury House in January 2013, 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 in this environment and some were not relevant. We noted many care and planning records were not signed or were undated. Support plans did not identify when people began using the service, or why they did so. We asked the provider to take action to put these things right. They sent us an action plan and we checked on this visit that they had made the improvements necessary to protect people from unsafe care.

We looked at three support plans in detail. We found they had been improved in a consistent way. It was clear at the start of any record when the person began using the service and whether this was for short stays or emergency placement. Folders were clearly indexed. Where a person had epilepsy, all related documentation was kept in one part of the folder. There was evidence that people staying at the home were directly involved in the content of support plans and risk assessments, or their family advocates were.

Plans and risk assessments showed evidence of review and a next planned review date was always shown. A senior support worker showed us they had a diary which contained all review dates, to ensure they would be carried out as planned. Each person's record also contained a form for recording all reviews. Key information, including the person's hospital passport, was kept near the front of folders.

All documents were signed and dated. Support staff were required to sign in each record monthly to show they had read it during the month. Staff we spoke with were confident they and their colleagues were up to date with the content of records. The provider may find it useful to note that when new risk assessments were formulated, their content sometimes overlapped with existing risk assessments, which could therefore have been withdrawn from use. This would ensure staff all used the most comprehensive assessment.

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.

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