Methodist Homes

Bradbury Grange

Inspection report

74 Canterbury Road
Whitstable
Kent
CT5 4HE
Tel: 01227 273209
Website: www.mha.org.uk

Date of inspection visit: 30 September and 1 October 2015
Date of publication: 12/11/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 30 September and 1 October 2015 and was unannounced.

Bradbury Grange is a care home which provides care and support for up to 50 older people. There were 49 people living at the service at the time of our inspection. People cared for were all older people; some of whom were living with dementia and some who could show behaviours which may challenge others. People were living with a range of care needs, including diabetes and Parkinson's.

Many people needed support with all of their personal care, and some with eating, drinking and mobility needs. Other people were more independent and needed less support from staff.

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

The service had a registered manager in post at the time of our visit. A registered manager is a person who has

Summary of findings

registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Bradbury Grange was last inspected on 16 and 17 March 2015. They were rated as requires improvement at that inspection. The Care Quality Commission (CQC) issued three Warning Notices after the inspection in respect of people's safe care and treatment and the staffing and good governance of the service. The provider was required to meet the Warning Notices by 16 June 2015. In addition we made Requirement Actions about the need for consent, recruitment processes and assessing and fulfilling people's individual care needs; and asked the provider to submit an action plan to us to show how and when they intended to address them.

We found that while improvements had been made in some areas, the provider had not fully met the Warning Notices or Requirement Actions during this inspection.

Medicines had not been consistently managed appropriately. Medicines rounds continued to take too long to complete in the mornings and records of medicine and creams administration had not been fully completed. This meant that it was not always possible to tell if people had received their medicines and creams as prescribed to them.

Some areas of the home remained unhygienic; including toilets, commodes and toilet seat risers. Toilet brushes were heavily soiled in some instances, but had not been included on cleaning schedules to ensure they were kept clean. There was no record or schedule of when people's bed linen was changed and some people remarked that they felt changes were infrequent. People's living conditions were not consistently hygienic.

Some equipment such as armchairs, side tables and toilet seat risers was either unsuitable or had not been properly maintained; creating risks to people using it.

Risk assessments had been put in place following the last inspection but were not always effective in providing guidance to staff about how to minimise risks to people's health and safety. Some recorded actions to minimise risks were not followed through in practice by staff; so people remained at risk of harm despite the assessments.

Although staffing numbers had increased; people's needs were still not being consistently met. Staff did not fully understand the ways in which people can experience abuse; and we observed occasions when people did not receive the care or attention they had requested.

People's consent to their care and treatment had not always been appropriately recorded; so the service could not evidence that it was acting in accordance with people's wishes. Assessments had been made of people's capacity to make their own decisions, but these were generalised and did not focus on specific decisions. These assessments did not conform to the principles of the Mental Capacity Act 2005.

The registered manager had received authorisation to restrict the liberty of one person in line with the Deprivation of Liberty Safeguards (DoLS); which are monitored by the Care Quality Commission (CQC). He had also made several applications for other people. However, some further people were having their liberty restricted but the registered manager had not applied for DoLS authorisations as he had not understood that this was necessary. The registered manager had not made statutory notifications to the CQC when DoLS applications and authorisations were made. This meant that the CQC had not been made aware when people's liberty was restricted in the service.

Guidance to staff about managing people's health needs had not always been followed; which meant people were sometimes exposed to increased risk. Staff had not received supervision in line with the provider's policy, to ensure they received support in their roles.

The quality of food on offer was largely criticised by people and relatives. During the inspection one person had sent out for food because their lunch had been "Inedible". When people had been seen by the dietician, guidance had been followed by staff to assist with people's nutrition needs but people had not always been referred to the dietician appropriately following weight loss.

The service was not always caring. People were not consistently treated thoughtfully by staff and some people and relatives told us how this affected their quality of life.

There had been some improvement in care planning since the last inspection but there was still a lack of

Summary of findings

information about promoting people's independence. There was insufficient detail in care plans about how people liked to receive support from staff and some plans had not been reviewed regularly. Some staff could not accurately describe people's preferences so there was a risk that people's choices might not be observed.

Systems to assess the safety and quality of the service had been ineffective in picking up the shortfalls that were found during this inspection. Audits and 'standards and values' checks made by the provider had not identified the on-going concerns around medicines management and infection control.

Although people, relatives and staff felt that the registered manager was likeable, many of them reported that management was ineffective within the service. The action plan submitted to the CQC had not been completed to target timescales set by the provider and Warning Notices about some areas of the service had not been fully met at the time of our inspection. The registered manager told us "It's my objective to make things right" but there had been insufficient improvement in the service since our last inspection.

New processes had been put in place around medicines to be taken as and when needed (PRN) and over-the-counter remedies. Staff had received up-to-date training in infection prevention and control and a designated staff member had been appointed as a lead to provide staff with guidance in this area. However, this had not sufficiently improved standards of hygiene in the service.

Staff had received fire safety training and could describe evacuation routes. Equipment such as hoists and the passenger lift had been routinely safety-tested.

There was a range of different activities available to people to help prevent social isolation. These included a chaplaincy service and in-house church services for those who wished to attend. Volunteers raised funds to provide people with special treats on their birthdays and at Christmas and Easter.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks to people were not managed to ensure their safety.

Staff were not deployed in a way which ensured people received safe care which met their needs.

The systems for the management of medicines were not always safe. People did not receive their medicines at the time they needed them, and medicine storage was not always safe.

Some equipment used by people was unsanitary or unsuitable.

Inadequate

Is the service effective?
The service was not effective.

The requirements of the Mental Capacity Act 2005 were not followed. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with the legislation.

Staff did not receive adequate supervision. There was no effective system in place to support staff and identify their training and development needs.

Meals were not always enjoyed and choices were not always as advertised.

Inadequate

Is the service caring?
The service was not caring.

Some staff were thoughtless when supporting people. When people were distressed or required support, staff did not always respond to them and people were ignored.

Peoples' dignity was not always considered.

Inadequate

Is the service responsive?
The service was not responsive.

Care plans did not always contain sufficient and up to date information about people's needs to allow staff to deliver care in a responsive and personalised way.

Complaints were not addressed. Most complaints were not recorded or responded to. People and relatives had no faith in the complaints process.

People had a choice of activities, but there was a lack of activity provision for people with more complex support needs who received very little interaction or stimulation.

Inadequate

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

Action had not been taken to address previous breaches of regulations we had identified. A range of audits were in place, however these were not used to make improvements to the service people received. The system used to assess and monitor quality was not effective.

Statutory notifications about deprivation of people's liberty had not been made to the Care Quality Commission.

Leadership of the service was poor, and this impacted on the care and treatment people received.

Bradbury Grange

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 September and 1 October 2015 and was unannounced. The inspection was carried out by two inspectors.

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

We met and spoke with 12 people who lived at Bradbury Grange and observed their care, including the lunchtime meal, medicines administration and activities. We spoke with four people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with 11 of the care workers, kitchen staff, the chaplain, volunteers, the registered manager and the service manager.

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

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

Inadequate

Is the service safe?

Our findings

One person told us, "I'm perfectly safe here-If I need help, I get it". Another person remarked, "The staff are lovely people and wouldn't intentionally hurt or neglect anyone". A relative said, "I have absolutely no peace of mind because I don't honestly feel that X is safe all the time. Another relative said that their loved one was "Frightened all the time because they hear other people call for staff but they don't always come".

At the last inspection on 16 and 17 March 2015, we reported on a range of areas where people's safety in Bradbury Grange was not ensured. The provider had addressed some of these areas but had not made adequate improvements in key areas and people remained at risk of receiving care which was not safe.

At the last inspection we found that medicines had not always been properly managed to protect people from risk. At this inspection, records of when medicines and creams had been administered had not been consistently completed. Some signatures were missing from medicines and creams administration records, so it was not always possible in retrospect to tell whether people had received their medicines or creams as they had been prescribed to them. One person had a cream that was prescribed for application once a day. The cream administration record had not been signed to show that it had been applied on 18 days during the previous month. This person had been assessed by the service as at risk of dry skin and the actions recorded to minimise this risk were for staff to apply their creams. Another person had been prescribed a pain relieving gel, and the instruction shown on medicines records was to apply twice daily. However staff had not signed to show that it had been administered on 10 occasions during the previous month. Staff had also failed to sign to confirm administration of eye drops, a laxative and a blood pressure medicine on single occasions; without any recorded explanation.

Some prescribed creams and sprays were stored in people's bedrooms. Although there were lockable cabinets available within people's en-suite bathrooms, these had not been used for creams. Bottles of sprays and tubes of creams were found on shelves, toilet cisterns and under a sink in one instance. No assessments had been made about any potential risk of creams being accessible to people or visitors. Some people were living with dementia or could be confused. There was a risk that they might apply more of the creams and sprays than had been prescribed for them. The deputy manager said that they had not thought about risk assessing the storage of these creams and confirmed that the lockable cabinets in bedrooms were not generally used.

At our last inspection we found that medicines rounds were still being carried out at 10:30 am; having started at 8am.During this inspection, medicines rounds were observed to finish at 10:30am on the first day and 11:10am on the second day. Medicines should be administered within one hour either side of the prescriber's instructions; so between 7am and 9am in the mornings. One person who received medicine at 10:20am was due a further dose of the same medicine at 12:30pm. Staff said that they would "Leave them until last" on the lunchtime round which meant they would receive the second dose at around 1pm. This would mean that there was only three hours between this person's medicine doses. We brought this to the immediate attention of the registered manager, who contacted the person's GP to confirm that no harm would be caused by them having two doses of their medicine at short intervals. However, other people also received their medicines later than was shown on medicines administration records. Morning medicines were recorded as given at 8am but staff actually administered them anytime up to 11:10am. One person said, "I'm meant to have my tablet before breakfast but that doesn't always happen". The records gave the impression that people had received their medicines at 8am.This meant that the information was inaccurate and it was not possible to check the actual administration times. Staff told us that it was, "Normal" for medicine rounds to take up until 10:30am to complete and the registered manager said that some staff were "Still learning" which was why the round was not completed until 11:10am on one day. The registered manager said that a monitored dosage system had been introduced to cut down on the time medicines round took to complete. Although the new dosage system was in place it had not adequately addressed the length of administration rounds.

The failure to ensure medicines are stored and administered safely, and recorded appropriately is a continued breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

At the last inspection we reported that some areas and equipment within the service were not clean. At this inspection sufficient improvements had not been made to ensure people were protected from the risk of infection arising from poor infection control in the service. Toilet brushes were found to harbour faecal matter and some commodes, toilets and seat risers had not been adequately cleaned on their undersides. Cleaning schedules and audits did not include toilet brushes which meant there were opportunities for them to be missed. Open waste bins were in use in many en-suite bathrooms and used continence pads were seen in one of these. In one communal bathroom, soiled latex gloves had been left balanced on a wall-mounted clothes hook. Clinical waste such as used pads and gloves should have been disposed of appropriately into special yellow bags. Older people can be prone to infection; and lapses in hygiene and cleanliness increases risks to them. The registered manager told us that he had doubled the cleaning hours spent by domestic staff following the last inspection. This additional cleaning resource had not still achieved appropriate standards of hygiene.

At the last inspection we highlighted that there was no proper schedule or records for changing people's sheets. At this inspection the registered manager had not put one in place. One person told us, "Goodness knows when my sheets were last changed" and a relative said "Sheets are not changed often enough". They described how they had noticed a stain on their family member's sheets which they said was "Still there five days later". Staff said that sheets were changed once a fortnight in first floor bedrooms and every other day on the ground floor. Staff could not clearly explain why there were different timescales on each floor. They said that although there were no records of linen changes they "Just know" when they were due. The registered manager said that it was the duty of care staff to change sheets and not cleaners or housekeepers. The provider had sent us an action plan following our last inspection to which stated that a 'bed changing schedule' would be in place by 5 May 2015. The lack of a system to ensure timely sheet changes meant that it was possible for these to be missed. This did not ensure good hygiene for people.

A small freezer in the first floor dining room contained a large tub of ice cream and an unwrapped ice cream dessert. Solid ice had formed around and over the freezer door seals; to the extent that the door could not be properly shut. Ice cream can present a risk of bacterial infection if it is not stored properly. We brought this to the immediate attention of the registered manager who told us that he would defrost the freezer straight away and dispose of the ice cream products that had been stored there.

Although staff training in preventing and controlling infection was now up-to-date and staff knew which member of staff had been designated as the lead in this area, this had not led to sufficient improvements to ensure people were protected from the risk of infection arising from poor infection control in the service.

The failure to ensure appropriate standards of hygiene is a continued breach of Regulation 15 (1) (a) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Toilet seat risers in two people's en-suite bathrooms had not been secured to the toilet bowl and were just resting on the pan. This meant that the seat risers could move about freely if people sat on them; posing a risk that they might slip and fall from them. One person whose seat riser was not affixed had been assessed at very high risk of falls and had slid off an armchair in the past.

Some of the furniture in the service was unsuitable for use by older people or those with mobility impairment. For example; some armchairs had shallow seats. When pressure relieving cushions were placed on top of the existing seat, people were raised up to a position almost level with the chairs' arms. This could make it more likely that people would slip from them and we observed one person repeatedly sliding to the front of their armchair. Low coffee tables were in use and we saw that some people had to bend right down to pick things up from these; again presenting a risk that they might overbalance and fall.

The failure to provide suitable equipment and to properly maintain some items is a breach of Regulation 15(1) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection we reported that assessments about people's health and welfare had not always provided sufficient guidance to staff about how to minimise risks to people. At this inspection we found that some risk assessments remained inadequate and this placed people at risk of harm. For example; staff moved one person using a special belt designed for this purpose. The person's moving and handling assessment did not mention that the

lifting belt could be used to help staff to move or reposition them. There were no directions included to instruct staff how this manoeuvre should be safely carried out. Where people were at risk of poor skin integrity, risk assessments did not contain any detail about how frequently people should be taken to the toilet or have their continence pads changed, despite one person having had a sore area caused by moisture.

Other assessments recorded how risks should be minimised but the instructions were not followed through in practice. Staff sat two people onto special air flow cushions; which are designed to help prevent pressure wounds developing. Staff told us that the level of airflow to the cushions should be determined by the person's weight and could be adjusted by a dial on an electric pump. Risk assessments showed that these people were at risk of pressure wounds and that air flow cushions and mattresses should be used; and that they must, "Be checked daily for the right setting". Staff did not check the airflow levels when seating people onto these cushions. Both people's cushions were set at the wrong levels for their weights. One person's mattress was also at the incorrect setting for their weight. This may have made the pressure-relieving equipment less effective. We brought this to the immediate attention of senior staff who said that they did not know why cushions and mattresses had not been adjusted to reflect people's current weigh.

Further risk assessments advised staff to encourage fluid and hydration and staff did record people's fluid intake. Sometimes fluids were totalled-up at the end of each day, but discussion with staff showed a lack of common understanding about how much fluid people should be encouraged to drink. There was no guidance about target amounts of fluid to be consumed or what action staff should take if this was not reached. This posed the risk that staff might not escalate concerns appropriately.

Another person had been assessed as needing two-hourly checks by staff when the person was in their room to keep them safe Records of these checks showed that they had not consistently taken place every two hours. On one date in the two weeks prior to our inspection, checks were documented at 9pm and 12:45am only. On another date these had been conducted at 10:30pm and 12:50am and there were no records at all for another date in that period. Staff said that the room checks had been put in place because this person had fallen when the room sensor had not been activated. They could not explain the gaps in the recording of the checks. People had not been protected from identified risks to their health and safety.

The provider had failed to adequately assess risks to people's health and safety and to do everything practicable to mitigate those risks. This is a continued breach of Regulation 12(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection we found that people had not been protected by robust recruitment procedures; because proper pre-employment checks had not been carried out. During this inspection four recent recruitment files were reviewed. References and Disclosure and Barring Service (DBS) clearance had been sought for new staff. A Disclosure and Barring Service (DBS) check identifies if prospective staff have had a criminal record or have been barred from working with children or vulnerable people. However, the provider had not formally assessed and mitigated the risks of employing staff who had a previous conviction. The registered manager explained that they had received good references for staff member and had not felt that they posed any risk to people living in the service. He said that he had discussed the matter with the provider's human resources department and did not want to treat staff with a former conviction differently to others. This meant that people were not always protected against the risks of recruiting potentially unsuitable staff.

The provider had failed to protect people with a robust recruitment procedure. This is a continued breach of Regulation 19(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection we reported that there were not enough staff on duty to meet people's needs. We also found that staff did not did not interact with people and were task rather than people focussed. At this inspection, staffing numbers had been increased, but this had not resulted in people receiving care which was safe or met their needs.

Some people and relatives said that staff took a long time to answer call bells; which made them feel unsafe at times. One person told us "They just don't come-I know I have to wait my turn but it goes on and on". A relative said that their loved one was often fearful because they could hear call bells and shouts for assistance that went unanswered

Is the service safe?

for long periods. Two people and two relatives told us that there were enough staff to help people but that some staff were "Slow" or "Lazy". The registered manager said that call bells should be responded to within five minutes. The provider's action plan said that all call bells not answered within five minutes would be reviewed with the staff and resident involved. This had not always happened. A call bell audit for September 2015 showed that some calls had taken much longer than five minutes to be answered. On one date, the audit information documented that a call took 30 minutes to be answered by staff. Other calls took 10, 11, 18 and 21 minutes. Although some staff had been spoken to about the 30 minutes delay, the registered manager said that he had not yet addressed the other incidences. He also told us that he felt that the audit information must be incorrect and said he would investigate this.

People were still sitting at lunch tables at 2:20pm on one day of our visit. Three staff were in the dining room with those people but were not assisting or interacting with them. The staff were talking among themselves while people sat at empty tables which had been cleared following lunch. Other people were sitting in the lounge area with no engagement from staff for long periods. In the morning several staff had walked past a person who was calling for assistance; without stopping or talking with them in any way. Staff did not appear hurried but did not react to this person. We observed this person trying to push themselves up from their chair on several occasions. Staff did reposition them on one occasion, but at other times there were no staff in the lounge to see the person trying to stand up. This person's care file included information about their risk of falling and medical conditions which increased the possibility of bone fractures. The document went on to say that the person would make attempts to get out of their chair so staff should be vigilant to prevent any "Untoward incidents". The provider's action plan stated that staff would be allocated to supervise lounges but this had not happened in practice and the failure to deploy staff appropriately left people at risk.

Although staffing had increased, the registered manager had not ensured that staff on duty had the right mix of skills, competencies, qualifications, experience and knowledge to provide the necessary care and support to people. For example, when we spoke with the registered manager about the length of time medicine administration took, he told us it was because staff administering medicines were new and were not familiar with the routine. This did not protect people or ensure they received their medicines in a timely manner. The registered manager had not ensured that staff were sufficiently trained and knowledgeable prior to undertaking this task. When we looked at how staff ensured people's healthcare and nutritional needs were met, we identified that staff were not following advice of health professionals, and this had increased the risk of poor health for people who needed extra care when they had become unwell. We observed staff on three separate occasions moving people in a way which caused harm or distress. People's discomfort and one person's distress was ignored in all instances.

The registered manager explained that monthly dependency profiles were completed to detail each individual person's care needs and we saw these in care files. The service manager explained that this information was then collated and considered by him, to determine whether any extra staff were required. The registered manager stated that eight day staff and four at night were "Baseline" levels which would not decrease; even if people's dependencies lessened. However, the dependency profiles meant that staffing would increase if people had greater needs. Although the registered manager said that staff grades and skills had been taken into account in the staffing of the home, our observations showed that people did not always receive safe or appropriate care from them.

The failure to deploy suitably qualified, competent, skilled and experienced staff is a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Although staff had received training about protecting people from abuse, they showed a lack of understanding about the different forms that this can take. For example; staff knew that bruising could be a sign that a person was being physically abused, but did not appreciate that ignoring people's calls for help or failing to reassure people in distress could be deemed to be neglect or psychological abuse. During the inspection we observed incidences where some staff did not respond appropriately to people and we heard examples from people and relatives about other occasions when needs had been disregarded. A

Inadequate

Is the service safe?

relative told us that staff persistently failed to ensure that their family member had a communication aid, despite reminders. This had left the person feeling frustrated and unable to properly engage with others.

People had not been protected from abuse and improper treatment; which is a breach of Regulation 13 (1) (4) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Accidents and incidents had been recorded and investigated and action plans put in place to prevent reoccurrences. For example; where people had fallen, investigations had been carried out and recorded to determine the reason for the incident. One person was found to be wearing slippers that were loose and action had been taken to replace these. Another person was discovered to have an infection which had affected their balance and the care plan gave directions to staff to help prevent future infections.

Environmental risks such as electrical and water safety had been assessed and equipment including the lift and hoists had been regularly serviced. Monthly safety checks of wheelchairs had been documented.

Individual fire evacuation plans were held for people and regular fire drills had been logged. Staff had received fire safety training and knew the process and route to follow in the event of an emergency. The service had arrangements with a local church so that people could be evacuated and cared for there if necessary.

The service had introduced individual protocols for people who took medicines 'As and when required' following our last inspection. New processes had also been put in place around over the counter medicines. This meant that staff had detailed information available about how and when people could be given medicines; which improved safety in these areas. Temperature recordings of the medicines room and fridge had been competed daily to ensure that medicines were stored in a suitably cool environment. Medicines had been returned to the pharmacy promptly when necessary; and records were kept to show when this had happened. This avoided large quantities of medicines being inappropriately stored within the service.

At the last inspection we found that the slings used to help hoist and move people had not been stored or cleaned hygienically. At this inspection, people had been assigned individual slings to reduce the risk of cross-infection.

Inadequate

Is the service effective?

Our findings

One person told us, “Meals are very disappointing here”. Another person said, “The food’s OK-I get enough”. A relative commented “ Staff do ask X if it’s ok before they move her, but she’s never been approached about giving written consent to her care”.

We checked to see whether people’s rights had been protected by assessments under the Mental Capacity Act (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making.

At the last inspection we found that assessments had not been made about people’s capacity to make certain decisions. At this inspection we saw that the registered manager had introduced mental capacity assessments. However these were not decision-specific, but based generally around decisions people may need to make within the service at some time. This showed a continued lack of understanding of the principles of the MCA.

Consent forms were in place for people to give their permission for photographs to be taken, for outings and giving people access to care information. Signed consent had been obtained from people who had been assessed as not having capacity; and in two cases staff members had signed on behalf of people. Staff had received training about mental capacity but the provider could not always evidence that they had acted in accordance with people's own wishes.

Do not attempt resuscitation (DNAR) orders recorded details about people’s capacity to be involved in decisions about their end of life which contradicted other assessments of capacity made by the service. When people’s capacity to make decisions had changed, the DNARs had not been reviewed or updated to reflect this. This was important to unsure that people’s rights had been protected.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

The registered manager had submitted six applications to restrict people’s liberty; and one application had been authorised. However, other people lacked capacity and had restrictions in place, but applications had not yet been made for DoLS authorisations. The registered manager told us that he had not understood the need to make DoLS applications in some of those cases but would now do so.

The failure to appropriately obtain people’s consent is a continued breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People had access to health professionals, such as doctors, nurses and a dietician. Records of any health appointments or contacts were recorded together with the outcomes. However we found that a request for interventions from a doctor had not been followed through. A doctor had requested that a medicine was stopped and that blood sugar levels were tested at intervals that changed as the treatment progressed. If a test showed a level of 10 or above the doctor should be contacted for advice. Records showed that tests were not undertaken in line with the doctor’s requested frequency and when tests showed a reading of 10 or over there was no record that the doctor had been contacted for advice and guidance.

Records showed that one person was at risk of urine infections and had had several infections. The risk assessment had been reviewed and the action to reduce this risk had been recorded as ‘Introduce a fluid chart on 8 August 2015’. However records showed that the chart had not been implemented until 30 August 2015; leaving this person at risk of a further infection.

The provider had failed to properly assess risks to people’s health and had not put in place safe procedures to ensure their health and welfare. Care and treatment did not always meet people’s needs. This is a continued breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff had completed Skills for Care common induction standards, which are the standards people working in adult social care need to meet before they can safely work unsupervised. All staff had a six month probation period to assess their skills and performance in the role. Staff had received training specific to their role. For example, infection control, emergency first aid, fire, food safety, nutrition, moving and handling, health and safety and equality and diversity. This was refreshed regularly so staff

Is the service effective?

knowledge was up to date. However although staff had received training we found their practices did not ensure people received effective care. For example, staff's moving and handling practices did not always show people were treated with dignity and respect when being moved or that people were moved safely. In other cases a lack of thoughtlessness or proper understanding of people's needs meant the quality of care they received did not meet their needs. For example, people not assisted to wear their hearing aids and items put out of reach of people.

At the last inspection, staff told us that changes had been made and non-senior staff were expected to review care plans. Staff said they had not received any training to do so and did not feel confident in this task. At this inspection, ten staff had been identified as requiring care planning training, but only four staff had received it at the time of our visit.

At the last inspection the registered manager confirmed that the provider's policy was that staff should receive individual supervision meetings at least six times a year in addition to an annual appraisal. The provider's action plan; sent to us after that inspection, stated that supervisions would be completed for all staff on a bi-monthly basis. However, records showed that most staff had only received one supervision session during 2015. This meant there was a lack of support and monitoring to ensure staff were carrying out their duties and undertaking their responsibilities effectively, in order to meet people's needs effectively and legislative requirements.

Most staff had also received an annual appraisal meeting during 2015; when their learning and development had been discussed. However the lack of regular supervision to enable a thorough appraisal of staff's practices and knowledge had resulted in people receiving inadequate care and support. Three staff meetings had been held since the last inspection, where practices and procedures were discussed and reiterated. However these were not effective as we saw that staff had been reminded to review care plans over the month so they were all reviewed at least monthly, but they were not.

The provider had failed to ensure staff received appropriate training, supervision and support to enable them to undertake their roles. This is a continued breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's comments about the food were mixed. One person said "It's quite good, we get a choice and they ask us the day before" but another person told us, "The food is diabolical here; no fresh veg-it's all tinned or frozen and the pastry is inedible". Other people commented that the meat was, "A bit tough" or the chips were not really hot.

The menu during the inspection was changed on both days and this resulted in people not receiving a real choice. On the second day of the inspection the choices for main course were vegetable curry or vegetable gratin; which was topped with a crumble mixture. This was followed by fruit crumble; and there had been no meat or fish alternative offered for lunch. People were not complimentary about the curry with one person telling us "It was disgusting". Another person told us they had asked their relative to go and get something from the shop as they could not eat it.

People's nutrition needs had been assessed and guidance about how to meet these needs were recorded in the care plans. People's weight was monitored at least monthly, although at times risk assessments stated this should have been more frequent. This meant that the people identified at risk from losing weight may suffer further deterioration in their health because they were not being monitored properly. Most people had been referred appropriately to health professionals when staff were concerned about people's appetite or weight. However we found that one person had lost considerable weight over the last three months and although they had seen their doctor no referral had been discussed regarding the weight loss and involving a dietician. This meant the person had continued to lose weight and no action had been taken to reduce the risks to their health.

The registered manager told us this would have been identified at the end of September when he received the weight records for that month and he would have ensured that action was taken.

The provider had failed to ensure that the care and support was meeting people's nutritional needs and had regard to their well-being. This is a breach of Regulation 9(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

When people had been seen by the dietician; guidance had been followed through into practice by staff. People had their food liquidised if they had swallowing problems and

others were prescribed meal supplement drinks. Aids and adapted equipment were used to help encourage people's independence when eating and drinking, such as sectioned plates and adapted cutlery.

The menu was rotated every three weeks. People were asked their choice of meal the previous day. Each day there was a main meal and a vegetarian option; there was also a choice of puddings. In the evening there was a light meal, soup or sandwiches plus a choice of something sweet.

Special diets were catered for, such as diabetics, vegetarian and low cholesterol. The menu for the day was displayed in the corridor and also in the dining room. People told us they could choose where to have their meals.

At the last inspection we found that information about people's health conditions had not always been adequate. At this inspection there had been some improvements. For example; information had been obtained from NHS choices about diabetes. Care plans now contained information about signs and symptoms if a person became unwell due to their diabetes; and what staff should do. Staff signed to indicate they read and understood the care plans.

Inadequate

Is the service caring?

Our findings

One person told us, "I'm exceptionally happy here; staff are all kind and helpful to me" and another person said, "Staff are wonderful-I can't fault them". However, a further person remarked, "Some staff are really brusque with me, saying; I'm busy, I'm busy all the time" and another that "None of the staff here care enough, that's for sure".

Some staff did not always act in a caring way towards people. Care plans contained details about people's individual life histories but one person told us, "Staff don't know anything about the wonderful things I did in my life before I came here. I could tell them such stories but they're just not interested". Not all staff were able to tell us about the things which were important to the people living in the service.

Other people described how some staff could be "Thoughtless" and leave their possessions on side tables out of their reach; instead of placing them where they could be picked up easily. A relative told us that their loved one had often been left without an aid they needed to help them. These things could affect the quality of people's lives in the service and one person tearfully told us," I can't call this my home".

There were two instances where more thought could have enhanced people's dignity. In one case a person was left holding a bowl of soup and had the bowl in one hand and a spoon in the other resulting in the soup spilling all down the person's top. They had no food protector on and there were no staff present in the lounge at the time. Once brought to staffs' attention they did intervene to assist the person and then gave them a sandwich, which was more suitable for the person to eat independently. In another case, people were eating their main meal in the dining room and although some had finished others had not. Staff were asking people their choice of food for the following day while they were still eating their lunches; people were not allowed the dignity of finishing their meals at their own pace.

We observed staff pushing one person in a wheelchair towards the dining room with the person's Zimmer frame wedged around the person's legs. When they arrived at the dining room entrance the staff pulled the Zimmer frame off the wheelchair causing the person to flinch and rub their leg. The person told us they had only just been helped to get up at 11am and had not had their breakfast yet. They were upset about this as they had wanted to get up earlier but their wishes had not been respected.

Another person in a wheelchair had not had their feet placed onto the footrests before staff moved them. As they were pushed into the lounge, one of their feet was dragged backwards. Staff did not seem to notice this and the person was unable to communicate if they were in discomfort.

We observed a person being moved with a special belt designed for the purpose. The person cried out and asked staff to stop but they ignored the request. Staff did bring this person a cup of tea immediately afterwards, but they had not offered any reassurance or comforting words during the move.

The failure to provide people with appropriate person-centred care to meet their needs and reflect their preferences is a breach of Regulation 9 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Two staff were gentle and compassionate when supporting people. They covered people's legs with blankets when they used hoisting equipment, to protect their dignity and asked people discretely if they needed the toilet. We observed the same two staff kneeling on the floor to make eye contact with people while they chatted to them and others ensuring that curtains were slightly drawn to ensure people were not sitting in direct sunlight.

Care plans included information about people's preferred name and we heard these being used during the inspection. Two staff explained exactly what they were doing when they supported people with special equipment and engaged in friendly small talk while they helped people with their meal.

The service had an active volunteer's group which provided small gifts for people on special occasions and organised activities and fund raising events.

The registered manager told us no one using the service had needed to use an advocate, but contact details and information were available within the entrance hall for anyone who might wish to seek assistance.

Inadequate

Is the service responsive?

Our findings

One person told us, "I do like to see the hairdresser-it makes me feel nice" and another person said they enjoyed the volunteers' coffee mornings. One relative said "You try to raise concerns here, but they're met with the same response; which is- leave it with me and I'll get back to you-except nobody ever does".

At the last inspection we reported that people's care plans did not always reflect their wishes about how they received support with their personal care. At this inspection we found that some care plans had been improved to include this information. For example, "Likes to apply her face cream and will do her make up". "Prefers a shower to a bath". "Doesn't like soap on her face".

However the majority of care plans seen continued to lack detail about people's personal care routines and their preferences and wishes in relation to this.

The care plans did not record what people could do for themselves and what support they required from staff to develop or maintain their independence. For example care plans stated 'needs assistance with personal care'. 'Encourage (person) to do what she can for herself'. 'Likes to be as independent as she can, she requires one carer to assist her with her personal care and showering'. 'Has assistance with toileting'. 'Will have a shower whenever she needs one with assistance from one member of staff'. 'Has full assistance with her personal care needs try to encourage (person) wash the parts she can reach'. These statements did not inform staff how they should support people and did not ensure that people received their care in line with their wishes. The lack of detail meant that staff might not adopt a consistent approach in encouraging independence. This was despite one care plan stating that a person 'needed to use her independence to maximum potential'. We asked staff about people's individual preferences and routines but not all staff were able to accurately describe them. People might not receive care and support in a way that they liked if staff did not have sufficient information to guide them.

People's care plans had been developed from pre-admission assessments and observations made within the service. Pre-admission assessments contained information about needs relating to mobility and dexterity, breathing, personal care, eating and drinking, continence, socialising, communication, sleeping, spirituality and religion, health, emotional/mental well-being, tissue viability and maintaining a safe environment. People told us they or their family had visited the service prior to moving in. A care plan review sheet showed that a review of care plans should have been carried out every six months, but we found care plans with no records of any review at all or the last review had taken place more than six months ago. There was no evidence of people or their relatives being involved in care planning or care plan reviews. The registered manager acknowledged this was an area which needed improvement.

The provider had failed to ensure that care plans fully reflected people's needs and preferences and remained up-to-date; this is a continued breach of Regulation 9 (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

A complaint was reported during the inspection and this had been recorded in the complaints log and was to be investigated. Another complaint was also reported during the inspection and was being dealt with by the service manager. This was partly in relation to the time a person had been assisted to get up that morning. There had been no other complaints logged since the last inspection; but two relatives told us that they had raised concerns verbally which had not been addressed. One person living in the service told us they would speak with staff if there was a problem. They were confident it "Would be sorted out although this may take its time". However, other people and relatives told us that they had "Given up" raising any concerns with the registered manager. One relative described how he was "Never available to take my calls" and another remarked that the registered manager "Avoids eye contact with me now because he knows he hasn't dealt with the things I asked him to sort out". There was a complaints procedure displayed within the entrance hallway and this included the timescale that people could expect a response by. The registered manager told us that any concerns or complaints were taken seriously and used to learn and improve the service but we did not find evidence that this had happened. Although people and relatives told us they knew how to make complaints; and believed they had done so, there were only two complaints logged since the last inspection. There was no evidence that the concerns brought to our attention during the inspection had been logged, investigated and responded to by the registered manager.

Inadequate

Is the service responsive?

The lack of a consistently effective system for identifying, receiving, recording, handling and responding to complaints is a breach of Regulation 16 (2) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Although people had opportunities to provide feedback about the service provided in resident's meetings, their feedback was not always acted upon. Minutes showed that people had asked that menu boards were written in white chalk and that the person writing the board pressed hard as these were difficult to see. During the inspection one menu board was written in blue chalk. This showed feedback from people was not acted on to improve the quality care provided.

The provider had failed to involve people in decision making and take account of their opinions in the way in which the regulated activity is carried on. This is a breach of Regulation 9(3)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People had a programme of leisure activities in place. Most people we spoke with agreed there were things to do. One person said, "There are some activities, like music- I am not bored there are people to talk to". The activities for the day were displayed so that people could see what was on offer. Activities included a knitting circle, volunteers' shop, coffee morning, reminiscence, exercises, art and craft, music, scrabble, bingo and films. A visiting Chaplain also undertook activities, such as Holy Communion, prayers, bible reading and an evening service. Reflexology had recent started within the service and appointments were available every Wednesday.

The coffee mornings we were told, had started at the request of a couple living at the service previously. Both the men and ladies had separate coffee mornings at the same time where they could chat and catch up with other people. On the day of the inspection the men's coffee morning was attended by three people and a volunteer and the ladies was attended by approximately eight people, a member of staff and a volunteer. We heard about one morning when the ladies had discussed nursery rhymes and how this had been "Hilarious". There was plenty of laughter coming from the ladies coffee morning on the day of the inspection as well. On the first day of the inspection nine people had gone out to lunch as part of a 'lunch club'.

Other activities were not so well attended. Observations showed that the arts and craft was two people colouring in paper sheets with a member of staff. One lady told us how they were looking forward to the film 'The King's Speech' they had seen it before, but was going to watch it again. However the film on the second day of the inspection was attended by five people, four of whom we observed were mainly asleep. A hairdresser visited frequently and we saw people enjoying having their hair done; which they said made them feel feminine. Other people who had more complex needs spent large parts of their days in the lounge areas; where there was little to distract or engage them.

Inadequate

Is the service well-led?

Our findings

One person said, "I have absolutely no faith in the management of this home-the manager listens but then takes little action to put things right". Another person said, "There's just no leading force here". A relative told us, "The management of this home is wholly ineffective".

At the last inspection we reported on a number of areas where standards of care were either inadequate or required improvement. We issued Warning Notices in response to breaches of Regulations about safe care and treatment, staffing and good governance of the service. We also raised Requirement Actions about the need for consent, recruitment processes and assessing and fulfilling people's individual care needs. At this inspection the registered manager and service manager told us that they had been working tirelessly to make improvements. Despite these assurances however, we continued to find shortfalls in the quality and safety of care being provided at Bradbury Grange.

At our last inspection we reported that proper systems were not in place to assess and mitigate risks to people's safety and well-being. At this inspection we found that assessments continued to provide insufficiently detailed guidance to help staff to minimise risks. For example when people needed special equipment to help transfer them from beds to chairs, the risk assessments did not provide any information about actions staff should take to ensure that the move was carried out safely.

Other assessments identified specific risks to people and what should be done to mitigate them. However, these actions had not always been carried through in practice; meaning that people remained exposed to risk of harm. For example, risk assessments advised staff to encourage fluid and hydration and staff did record people's fluid intake. Sometimes fluids were totalled-up at the end of each day, but discussions with staff showed a lack of common understanding about how much fluid people should be encouraged to drink. There was no guidance about target amounts of fluid to be consumed or what action staff should take if this was not reached.

Some processes to monitor and improve the quality and safety of the service continued to be insufficient. For example; medicines audits had been completed quarterly and the service manager told us that provider checks were also made but that these did not look at everything in details and were a "Dip test". These checks had not identified the issues that we found during this inspection. The registered manager told us that he planned to introduce a peer review system so that administration records would be checked daily in future. The most recent medicines audit dated June 2015 highlighted that the timing of medicines rounds remained an issue. This had still not been appropriately addressed at the time of this inspection.

An infection control audit carried out a month before this inspection noted that toilets were unclean but did not record any actions taken to remedy this. A previous audit, dated March 2015 had identified toilets, commodes and seat risers as being dirty or stained and the housekeeper was notified of the issues. However, these areas remained unhygienic at this inspection; which meant that appropriate monitoring had not happened to ensure that the standard of cleanliness was improved.

The service manager and registered manager told us about provider quality audits which were carried out on a regular basis in the service to measure 'standards and values'. The most recent had been conducted the week before our inspection and had scored 91% achievement in meeting a range of standards relating to the quality and safety of the service. However, the provider audit had not been effective in recognising many of the areas for improvement that were found during our inspection.

A fire risk assessment carried out by an external professional contractor in June 2015 had made a significant number of recommendations which had been rated as 'medium risk'. Only two of the recommendations had been signed off as completed by the registered manager. We asked him about this and he said that this was a priority and that there was a meeting scheduled for late October to start a proper implementation plan. This planned meeting was a full six months after the report and recommendations had been made to the service. The registered manager told us that he would deal with the matters raised sooner and had made an immediate start during the second day of the inspection. However, risks to people's safety had been brought to the registered manager's attention in the report but had not been addressed within appropriate timescales.

Inadequate

Is the service well-led?

The failure to ensure effective quality assurance systems were in place is a continued breach of Regulation 17(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Statutory notifications about deprivations of people's liberty had not been sent to the Care Quality Commission (CQC).This is a requirement of the manager's registration because the CQC monitors the operation of DoLS which applies to care homes. The registered manager told us that he did not know that he was supposed to notify DoLS applications and authorisations. This meant that the CQC had not been made aware when matters affecting people's rights had occurred within the service.

The failure to send DoLS notifications to the CQC is a breach of Regulation 18 (1)(2) (d) of the Care Quality Commission (Registration) Regulations 2009.

Auditing of call-bells had shown delays of up to 30 minutes in staff answering them. Although the deputy manager had spoken to some staff about that delay, there were many others which had not been addressed. Everyone we spoke with including people, relatives, staff, the registered manager and service manager said that there were enough staff on duty. However we observed that the direction and deployment of staff was frequently lacking. For example; there were periods were there were no staff in the lounge with people. We checked and saw that three of the four staff on shift were talking to each other in the dining room. There was only one person in the dining room at this time and staff were not supporting them.

People were generally unhappy with the quality of the food served. We asked the registered manager about this and he told us that he was aware that people did not enjoy the pastry made by kitchen staff. He said he had investigated this and found that the cook was using double cream in the pastry; which made it heavy and unpalatable. There were no complaints logged about the food; including that made to the registered manager about the pastry. He said he had told the cook not to make pastry in this way in future and was considering starting a 'Food club' where people could meet with kitchen staff to talk about menus and food choices.

People, staff and relatives universally said that the registered manager was likeable. One person told us he was, "A very nice man" and "A genuinely well-meaning person". Another person said, "He's charming but that doesn't get things done". A relative commented, "He tries to please everyone but has no air of authority". People described how they had raised various issues with the registered manager but that they were rarely fully resolved. In particular, the people and relatives we spoke with were concerned about call-bell response times and the quality of food within the service.

Some staff told us the registered manager was "Great" but others said that they did not feel listened to and this sometimes had an impact on the delivery of the service. One staff member told us that they felt the registered manager was not effective or productive. They said, "All the staff are trying to pull together". They explained that sometimes jobs did not get done and were handed over to the next shift, but were not completed by them either. They gave an example of the "weekly weights" which had not been completed the previous Friday so were handed over to the weekend staff. At the weekend the "monthly weights" were also due to be done, but on Monday morning none of the weights had been completed. Staff on the morning shift also told us that the machine to test people's blood sugars could not be found so none had been tested that day. This had still not been located when staff handed over to the afternoon shift and created a risk that any changes in blood sugar levels would not be detected and addressed promptly.

Staff were confused about some procedures. For example, the registered manager told us that the post falls log was only used when a person injured themselves whilst having a fall, but one staff member told us they were always used. Records showed they were not consistently used confirming the confusion amongst staff. A staff member remarked, "It's ok here but it does sometimes feel like a rudderless ship".

The tumble dryers in the service had not been working and although a washing line had been erected this had not resolved the problem. We were told staff had taken washing home to dry, but there was still a shortage of laundered towels for people's baths. Staff also said that recently there had been no chemicals for the dishwasher resulting in cutlery and crockery not being appropriately clean.

The action plan which the provider had sent us following the last inspection listed some items which remained unaddressed at this inspection. These included the introduction of a bed-changing schedule, increasing staff

Inadequate

Is the service well-led?

supervisions and producing an effective individual toileting programme for people. The provider had not been effective in achieving their own targets to ensure all the necessary improvements had been made in the service. We found that although some areas were better and appropriate actions had been taken; other issues emerged about other aspects of care delivery and management. For example; a number of improvements had been made around managing medicines; such as developing PRN and over the counter remedy guidance. However, we then found that administration records had not been properly completed. This indicated that the service was finding it difficult to sustain improvements and maintain better standards. The registered manager told us "It's my objective to make things right" but our findings at this and the last inspection raised concerns about the registered manager's competency.

The provider's failure to ensure that the registered manager had the competence and skills to carry out his role are a breach of Regulation 19 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was a member of a local care home forum which he said he attended so that he could keep abreast of new information about health and social care. The registered manager was supported by a deputy and received regular support visits and supervisions from the service manager.

The service had a statement of purpose, which included the vision and values of the service. The service also had a service user guide, which had been updated since the last inspection. The service user guide was a booklet that enabled people to have detailed information of what to expect from the service. Both these documents contained the provider's 'mission'. The mission was 'To improve the quality of life for older people, inspired by Christian concern'. Although staff were able to describe the values of the service in broad terms, these were not always evidenced in practice during the days of our inspection.

People were kept informed about upcoming events, people's birthdays, people moving in, new staff and funds being raised together with projects organised by the volunteers through a newsletter.