Inspection Report

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

Bradfield Residential Home

Hawksdown Road, Walmer, Deal, CT14 7PW Tel: 01304360960

Date of Inspection: 25 October 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Safety and suitability of premises	✓ Met this standard

Details about this location

Registered Provider	Mr David James Johnson & Mrs Brenda Eileen Johnson
Registered Manager	Mrs. Brenda Johnson
Overview of the service	Bradfield Residential Home is a large detached property in a quiet residential area of Walmer near Deal. It is privately owned and provided care and support for a maximum of 32 older people. Extensive communal spaces were available in the home for people to meet or carry out activities. A passenger lift is available for access to the two upper floors. All but two of the rooms have en-suite toilet and shower facilities. A secure garden is available for people to use throughout the year.
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 25 October 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, talked with carers and / or family members and talked with staff.

What people told us and what we found

We looked at paperwork and found that people had the right support to give consent. People had a full assessment and a care plan, which were reviewed regularly. We saw that the service responded quickly when people's needs changed.

Medicines were managed in a safe way, and the environment was safe, helping people to retain as much independence as possible.

People had fresh, home cooked food. We found meals to be well thought out and people's preferences and allergies were known by the cook. Visitors were welcomed and supported to spend time with their friend or relative. The house had a friendly, happy, calm atmosphere.

We spoke with at least eight people, three whom we spoke with in detail. One person told us that 'There is always something going on, it's a good place to live, so warm and safe. The food is very good'. Another said 'I am not sure how they know what I like, but I always get the right things'. A third said 'I was not keen to come to a residential home, but this is the best thing. I hope I am around another ten years, I enjoy my life here'.

We saw that staff were busy, but they didn't rush. They responded in a person focused way that helped people, if they were confused, to be calm and confident. We spoke with a relative; they said their relative was happy, that they were always made to feel welcome. Staff told us they liked working here, that they enjoyed getting to know the people they support and were proud of giving quality service.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We looked at four care plan assessments and pathways to find out how the service supported people to give consent. We noted that all the people living in the service had a pre-admission assessment. The assessor had noted where it had been established if someone had been appointed to speak on the person's behalf if they lost capacity to consent in the future.

During our observations we saw that simple consent for direct care and treatment had been obtained by staff. We noted that staff were unhurried and gave people enough time to process information. For example, we observed a person needed extra support when they were disorientated. The care plan had clearly documented steps to support the person well. We observed that these were followed. The person asked for support to be given in a specific way during the observation. We saw that staff did not hesitate to do as the person requested. This meant that the person was reassured and respected. Further support observed recognised a person's changing needs and we noticed staff were calm and kind supporting them. We saw that staff provided a chair for the person to take a break and then make a decision. This meant that people were supported to give consent in a way that retained their dignity, which was in accordance to their wishes.

With the person in charge, we discussed how assessments were carried out to make sure consent was lawful. The person in charge told us that where people had been appointed to speak on the person's behalf, a copy of the notice from the office of the public guardian was obtained. The person in charge said that this was essential so that people who knew the person well could state their wishes. We saw that where people had not made arrangements for another person to give lawful consent, a best interests process was in place. This meant that the service remained independent from any complex decisions taken about care and treatment.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We looked at two specifically selected care plans in detail. We looked at the relevant sections of two other care plans and found that the following process had been thoroughly applied throughout. This meant that the assessment and care planning process seen focused on people's welfare and safety.

We found that a detailed pre-admissions assessment had taken place before people were offered a place at the home. The service at admission did not cater to people who had dementia. The person in charge said that supporting the changing needs of existing people was something the service strived to do. However, the person in charge said the service recognised when they were unable to meet needs. As this had happened, other professional support had been obtained. This meant that the home offered a service to people it could support well.

The care plans were written based on the assessment findings. We saw that subsequent changes had been made as people's needs changed. This meant that staff supporting people new to the service could do so in a way that the person was likely to prefer. When people's needs changed, the staff had a good knowledge of the individual. This meant that people, where they had stated it was their wish, were able to remain at the home until the end of their life.

We saw evidence that care and support plans had considered a wide range of matters. These had been presented in an easy to read manner. For example, the risk assessment process looked at a range of essential areas (skin integrity, continence, falls, nutrition and so on). For each area a risk rating had been given (low risk – high risk). Where needed a control measure was stated. For more complex support a further control measure with detailed support planning had been included. All risks had been reviewed on a six month cycle. We noted that a detailed note of all support adjustment had been kept. This demonstrated that risk and support had been adjusted and staff briefed as and when the person's needs changed. This meant that the service was able to provide safe and relevant support, rapidly responding to individuals changing needs.

We spent about an hour and half observing people receiving care and support over a Friday afternoon. We saw that activities were offered in small groups. Some people spent time socialising with relatives and friends. Other people went to friends rooms and had tea and snacks in the room. We saw that each person was given the level of support they personally needed. For example, people who were independent were encouraged to retain their skills with minimal staff support. We observed that staff were fast to respond and offer support, but did so in a calm and gentle way. We saw that staff spent time sitting and chatting to people. During an activity, we spoke with the group who were decorating cakes. We asked them to tell us what was good and not so good about the home. The five cake decorators were unanimous to say that they enjoyed living in the home. They said that there was always something to do, something organised by the staff, or amongst the people themselves. We were told that '…you never have to wait long for staff. They are busy, but they are always available'. We asked the group if they felt treated well, and one person replied 'Oh good grief, yes, it really is very good. Very safe, and look how clean it is, we are very lucky'.

The service had a working relationship with the district nurse. We were told and saw records that showed where people had pressure sores. We noted that the support that was being provided was detailed and specific. The district nurse attended the service to provide regular dressing and advice. We saw that specialist equipment had been or was in the process of being obtained (such as air-flow cushions and mattresses). We noted that where people refused support and treatment, the person in charge had sought additional help from the mental health team and other independent professionals. This meant that the person had the best possible level of information to make a complex decision about their care and welfare. The service was then able to provide care and support within the limitations that the person would consent to. We noted that all support, where people had chosen an option that was unusual was honoured, but the risk was kept under regular review. This meant that the person retained their autonomy for as long as possible.

We spoke with another person who told us that they were unhappy about coming to live in residential care. But they said that it had been the best decision. They told us they hoped to live a long and happy life at the home. They were able to do exactly what they wanted, be left alone in the evenings and enough social life in the day. They told us 'The staff make sure I have enough beer, this is important to me. They sort out my laundry and cleaning. They really have got to know me, they know what I do and don't like. You hear a lot about these places [bad stuff], but it's not like that here'. This meant that the people living at the home felt respected and valued. They felt that their care and welfare was the staff and managements main concern.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People were provided with a choice of suitable and nutritious food and drink.

We observed that there was a dedicated cook employed by the home on duty that day. We were told that a cook was available seven days a week for main meals. Direct support staff were not expected to do the main catering. We spoke with the person in charge and the cook; they advised us that personal preferences had been catered for. They evidenced this by having a clear record of individual preferences, dislikes and allergies on a chart in the kitchen. We saw that menus were displayed in a folder in the kitchen. Menu's showed that a variety of food had been provided on a four weekly cycle. This meant that the service was mindful about providing a diet providing balanced nutrition.

We observed that staff were walking around speaking to each person individually about their meals. Staff would tell each person what was available as a main choice. For example, on the day of the visit, creamy chicken and ham pie with mash and vegetables was the main dish. Records showed that some people had declined this, but were provided with an equally nutritious alternative of their choice. We noted that people chose their meals in advance of the chef cooking them. We also noted that people had particular tables they sat at. The chef had devised a colour code system that helped them dish up meals per table. This meant that people got the food they preferred, fresh from the kitchen.

We spoke with eight people about food and everyone said similar things, for example, 'It's always good'. 'I don't remember how they know what I like, but I always get food to my tastes'. 'They always ask me what I want, and tell me what is on offer'. 'There is nothing to complain about'. The person in charge said that some people were put off with larger portion sizes. We saw in the care plan that where this was the case, it had been stated. This meant that people were given the right support to eat well.

We saw the care plans noted people's likes and dislikes. For one person, we noted that one pre-admission dislike had been noted. However records showed that this dislike around food seemed not to have been observed. We spoke with the staff and the person in charge. We saw further information that suggested tastes had changed, but the preference list had not been updated. We noted that this was an isolated, clerical error and did not reflect the attention to detail seen across the other plans. The person in charge said that they would make the adjustment to the records.

We noticed that staff were offering drinks (hot and cold) throughout our visit. We saw that staff delivered tea and other snacks to people in their rooms. Visitors were provided with snacks and meals if they wished. We asked the people we spoke with was it always like this? They said it was. A relative said that they often took a meal at the service so they could be with their loved one during the best part of the day. They told us nothing seemed to be too much trouble. This meant that people were getting the food and drink they preferred, providing adequate nutrition and hydration.

We saw records noted where people needed soft diets. We were told where a person had requested a softer diet as preference, this had been arranged. Specialist cups and utensils were available and were used based on the individual's assessed needs. Risk assessments, where needed, were in place to help staff understand how best to support people to take food and drink. This meant that people were protected from the risk of choking.

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

Appropriate arrangements were in place in relation to obtaining medicine. Medicines were handled appropriately and were safely administered.

The home had a safe system for administering medicines. Medicines were ordered on a four weekly cycle and were provided in handy packs, called a monitored dose system. These packs were divided into time, for example morning, noon and evening. All medicines were transported around the home in locked trolleys. As a larger home, there were three trolleys available, so people, if not self-administering, were close to their own medicines. This process meant that there was a safe way of transporting medication hygienically and safely.

All medicines were administered to people, where possible in the privacy of their own room. We observed that two people needed medicine in the middle of the visit. As the people were in communal areas, this was provided in a discreet and quiet way. A drink was provided and sufficient support given to make sure the people had consumed the medicine safely. We observed that the process the person in charge took made sure the right medicine was given to the right person at the right time.

We saw that the storage was discreet, safe, tidy and hygienic. All liquids and creams were seen stored in separate areas within the trolley. Any medication that needed refrigeration was stored in a dedicated, locked fridge. We saw that there was a system in place for ordering repeat medicines on a four weekly cycle. We were told that forthcoming medicines were stored safely out of the way until they were needed. Incoming medicines were checked in for correctness and signed in as correct on the recording sheet for each person. Before the start of the next cycle, the person in charge double checked the current medicines record with the new records to double check nothing had recently changed. This meant that people were protected from missing medicine or getting the wrong medicines.

We looked at the medicine administration records for seven people. We saw that all of the records had been signed to say medicines had been given. Where medicines were not given, a code had been entered to state why that was. We cross checked against people's care plans and noted that where medicine was not given, the doctor was aware. Actions

necessary to support people in such situations had been clearly documented. We noted that the medicine records were kept neatly. Each record was headed with a picture of the person. This additional picture had helped reduce administration errors.

All people had access to pain relief medicines based on their own preferences and allergies. Situations where pain relief might be needed, how people express pain and at what dose pain relief could be given was recorded in the care plan. Allergies were clearly recorded in the care plan records. This meant people were protected from prolonged pain and the risk of receiving the wrong medicines.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

The provider had taken steps to provide care in an environment that was suitably designed and adequately maintained.

The home had 29 bedrooms, three of which can be used for double occupancy. At the time of this visit, all bedrooms were singularly occupied. The person in charge told us that only people who knew each other well and wanted to share would share. All bedrooms had a hand wash facility, 27 had toilets and most of these had a private shower facility too. Two rooms had the use of commodes, but these bedrooms were located a short distance from a communal toilet. A system for emptying and cleaning commodes was in place. Every person we spoke with said that the environment was to their liking. Some were enthusiastic to say how clean yet like home the place was. One person said 'We are so lucky, look how glorious it is, and warm too'.

There were two communal bathrooms and one communal shower room, all of which had toilet facilities. A visitor and staff toilet was available separately.

We walked around the home and found that there were hand rails available throughout. In areas where there was a gap between handrails, solid furniture had been placed, should it be needed. Access to the two upper floors was by shaft lift of a sufficient size to accommodate a person using a standard size wheelchair and support worker.

There was a personal fire evacuation plan in place for each person, and as well as an external, well maintained fire escape, the service had 'evacumats'. These are slides that enable a person to rapidly descend a staircase while seated.

There was unrestricted access to a secure garden and patio seating area. These areas had seating and handrails for people to use.

Clinical waste was stored in smaller bins within the house. There was a contract disposal system for the collection of waste in place. The laundry was small but sufficient, with a dirty to clean route in operation. There was a sluice and domestic washing machine in place. We were told, and saw stickers, that mechanical hoists had services per manufacturer recommendations. Where people had purchased their own hoisting or

mobility equipment, individual records were seen on the support plan. These showed that people were supported to keep their equipment in safe order.

The kitchen was seen to be tidy and appeared hygienic. Dry food storage was well stocked and kept safely. The person in charge said that the environmental health officer had rated the service the day before the inspection. The feedback sheet indicated that the service had a high '5' rating for hygiene. There was a system for delivery of food to come into the home and directly into the larder and cold storage without entering the main house. This meant that the system in place kept food safe in a purpose designed environment.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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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