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The Brunswick

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 19 and 20 November 2018. The first day of inspection was unannounced.

The Brunswick is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The Brunswick provides accommodation and personal care for a maximum of 58 residents. Care needs for people using the service include older people, people with physical disability and people with sensory impairment. The service was registered 12 months ago and this was the first inspection. At the time of the inspection there were 36 people in residence.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission [CQC] 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.

We found management and overall governance was stable. The provider had other locations registered with CQC and was experienced in the care sector. The registered manager was a consistent lead in the home and had been effective in building a positive staff team.

Staffing numbers helped ensure people's care needs were being consistently met. Feedback from staff, people using the service and visitors was positive in that staffing levels were adequate to ensure safe standards of care. We looked at how staff were recruited and the processes to ensure staff were suitable to work in the home. We saw checks had been made so that staff employed were suitable to work with vulnerable people.

We found medicines were administered safely. People received their medicines consistently. Medication administration records (MARs) were not always clear and this was discussed with reference to future changes in some of the pharmacy arrangements.

People's nutritional intake was supported appropriately. There had been some negative feedback prior to our inspection and the provider had responded by reviewing the meal arrangements for people. Most people's comments on the inspection were that the meals had improved. Meal times were seen to be a relaxed and enjoyable experience for people. People's nutritional intake was monitored.

Staff told us there were very good systems in place to support them in their work such as training and supervision.

Observations and feedback from people and their relatives evidenced people's dignity was protected and

maintained.

The activities programme continued to be developed. A newly employed activities coordinator had made positive improvements to help ensure a more consistent programme of social activities had been developed.

People's risks regarding their health care were being adequately assessed and monitored. There was good referral and liaison with community health care professionals who worked with the home to help ensure people's health care needs were met.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. All staff were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. Planned development / maintenance was assessed and we could see the home was furnished to a high standard.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed and an assessment of the person's mental capacity was completed and decisions made in the person's best interest.

There were people being supported on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found these were being monitored by the registered manager of the home.

We saw written care plans were formulated and reviewed regularly. We saw that people and their relatives were involved in the care planning and reviews were held.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. People we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the right care.

A complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. There were records of complaints made and the provider or registered manager had provided a response to these.

The management structure within the home was clear and supported the home with clear lines of accountability and responsibility.

There were systems in place to gain feedback from people so that the service could be developed with respect to their needs and wishes.

The registered manager was aware of their responsibility to notify us [CQC] of any notifiable incidents in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Medicines were administered safely and in line with the provider's policies and procedures. We fed back some recording issues to be addressed.

There were enough staff on duty to help ensure people's care needs were consistently met.

Risks regarding people's health care were adequately assessed and monitored.

Staff knew how to recognise abuse and the action they should take to ensure actual or potential harm was reported

Is the service effective?

Good

The service was effective.

We found the home ensured people access support for their health care needs.

People were supported appropriately so their nutrition and hydration needs were met.

When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed and people were assessed and reviewed appropriately.

Is the service caring?

Good

The service was caring.

People's dignity was protected and maintained.

Staff showed a caring nature with appropriate interventions to support people.

There were opportunities for people and their relatives to provide feedback and get involved in their care and the running of the home.

Is the service responsive?

Good

The service was responsive.

There were planned social activities for people to engage in.

Care planning showed evidence that people and families had been involved in their care. Care plans were in place and regularly reviewed.

A process for managing complaints was in place and people we spoke with knew how to complain. Complaints made had been addressed.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place who provided ongoing support for staff and people living at the service.

Management and governance systems were consistently applied and helped to monitor standards in the home. The management structure within the home was clear and supported the home with clear lines of accountability and responsibility.

We found there was a positive and responsive culture in the home and the quality assurance system in place included consultation and feedback from people living at The Brunswick and their relatives.

The Brunswick

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 checked 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 was an unannounced inspection which took place over two days. The inspection team consisted of an adult social care inspector and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we spoke with commissioners such as social services and health care commissioners. They told us there had been complaints about the quality of the food; otherwise there had been minimal issues with The Brunswick.

During the visit we met and spoke with 19 of the people who lived at the home and nine visiting family members. We spoke with the registered manager and 16 staff including nursing staff, care/support staff, kitchen staff, domestic staff and senior managers for the provider. The providers were present during the feedback we gave.

We looked at the care records for five people as well as medication records, three staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives.

We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining and lounge areas.

Good

Is the service safe?

Our findings

All the people living at The Brunswick said they felt safe. Our observations were that people were relaxed in the home and in the company of staff. One person said, "I had falls before coming here but none since. I think staff have done really well and are there when needed." A relative commented, "I know [person] is safe here. Its first class; the staff know what they are doing."

We found that there were enough staff to ensure people were cared for safely. On the second day of the inspection there were some staff who reported sick and did not attend. The registered manager was able to cover the shift, however, at short notice. Staff told us this sometimes happens but mostly shortfalls are covered. People told us there were enough staff to ensure routine personal care such as bathing and assistance to dress was always carried out. A relative told us, "There's always enough staff so [person] can get a shower every day." Staff were observed to be supporting clients as they mobilised around the home and having conversations as this was taking place.

We were initially concerned about staff numbers at night [three staff for 36 residents currently] and how this might affect an appropriate response in case of an emergency. We were assured by senior managers that the staffing was routinely monitored as well as attention to staff awareness around fire safety. For example, there had been recent fire training which night staff had attended. People spoken with told us that there was always a quick response at night if they pressed their call bell.

There was also additional ancillary staff support such as administration staff, kitchen staff, laundry and domestic staff and a maintenance person. Additional staff hours were allocated for activities and there was a designated staff member to lead this.

Staff were recruited safely to ensure they were suitable to work with vulnerable people. We looked at three staff files and asked the manager and administrator for copies of applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were suitable.

We found medicines were being administered safely. People told us they received their medicines on time. Two people we reviewed were managing their own medicines and staff monitored this following the completion of a risk assessment to identify any risk. The assessments we saw included attention to safe storage in people's bedrooms.

People had a plan of care which set out their support needs for their medicines, including 'as required' (PRN) medicines. We checked medicine administration records (MARs) and found staff had signed to say they had administered the medicines.

Staff administering medicines were suitable trained and checked by senior staff to ensure they were competent. There were routine audits carried out such as stock checks by two of the senior carers and more in-depth audits by the registered manager and the regional manager; these helped identify issues of

concern. For example, there had been issues with delays in ordering of medicines due to local processes by GP's. The regional manager was liaising with the local Clinical Commissioning Group [CCG] to help address this. We spoke with a staff member who had worked in a number of previous care environments who told us, "The medicines are well managed here. There are clear systems which are easy to follow."

There were some anomalies with some of the Medication Administration Records [MARs] when we checked them. It was difficult to carry out a stock check for some medicines as the stock had not been 'carried over' on the MAR. Also, it was difficult to track quantities of stock in the Controlled Drug [CD] register because of the way audit checks had been entered. CDs are medicines that need to have special checks by law. Staff advised us that the way medicines were checked in was to be revised as receiving all medicines from the pharmacy on one day had been identified as an issue in ensuring all MAR's were completed accurately.

We saw the morning medicines round and medicines were administered to people following a safe procedure which followed good practice in terms of checking. The medicines trolley had a 'do not disturb' on the front to protect staff time whilst giving out medicines and reduce the risk of errors occurring. We saw this was not always adhered to; with both people living in the home and staff interrupting the medicine round at times. We discussed the potential risk although there was no impact on people at the medicines round as all medicines were given as prescribed; audits completed showed no medication errors. After the inspection we received an update from the manager who told us a senior staff meeting would consider further ideas to protect the time for staff to administer medicines.

There were records to track whether people had been administered topical preparations (creams). We saw a body map which recorded the areas of the body the cream was to be applied to. We saw that records of creams applied were not up to date. Some had not been completed for the morning medicines and some had gaps in recording on previous days. We were satisfied that the creams had been administered from our interviews with people. The manager advised the cream charts would be made more accessible to care staff in people's bedrooms instead of the central file they were currently kept.

Care records contained a range of risk assessments including; dependency, falls, nutrition, continence, moving and handling, pressure relief and generic risk. Assessed risk showed evidence of monthly review in each record. There was evidence of a falls risk assessment being upgraded following a person experiencing two falls. The person was now to be monitored more regularly and this was specified in the plan as well as a referral for health assessments.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All the staff we spoke with were clear about the need to report through any concerns they had. Contact numbers for the local authority safeguarding team were available.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed where obvious hazards were identified. The Brunswick had been newly registered a year ago and there had been much upgrading of the environment to ensure it was safe. We walked around the home and did not see any obvious hazards. We observed equipment such as hoists and slings were appropriately maintained. The home was clean with good attention paid to ensuring effective infection control. There were hand wash facilities in all communal bathrooms and toilets as well as easy access for staff to personal protective clothing [PPI]. A 'fire risk assessment' had been carried out. We saw personal emergency evacuation plans (PEEP's) were available for the people resident in the home to help ensure effective evacuation of the home in case of an emergency.

Good

Is the service effective?

Our findings

Prior to the inspection we had received some poor comments around the quality of the food. The provider had relied on an external catering company and people had not been satisfied with the meals provided. Managers had responded positively and had carried out a full review of the quality of the food because of these comments. There had been a switch to freshly cooked food on site and the employment of kitchen staff with a chef overseeing the quality.

All the people we spoke with agreed that things had improved. Most people said the food was now very good. A relative who had initially complained told us things were much better and the person they visited had said there had been "a vast improvement." Another person commented, "The food is splendid and has improved lately. Its cooked fresh now and we have a good choice."

However, a good proportion of people [six out of 19 people spoken with] commented that the quality remained inconsistent. One person said, "The food was appalling until the end of October and then improved suddenly. This week it has deteriorated again."

When we considered this, we found the chef had been on leave the week previously but was now back. Managers assured us that the kitchen was now adequately staffed to ensure a more consistent standard. We observed meal times and found these were well managed with plenty of staff support for people. People could choose where to eat their meals and some had meals in their bedrooms. The dining room was spacious with tables set up for four. The room was not cluttered; a consideration as several people had walking aids and wheelchairs. The atmosphere was calm and relaxing. Menus where on all tables with four choices for lunch and on discussion with the people it was acknowledged that this was new and not normal practice previously.

People we spoke with and relatives told us that staff had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. One relative commented, "Staff are confident and always make sure we are updated with any changes [in people's condition]." A person living at the home told us, "I found things difficult when I first came here but the staff were very patient and supported me well." The person's relative said, "[person] was very ill and now [they] are eating and have put on weight."

The registered manager informed us that mandatory and other training to all staff helped ensure staff were supported. Mandatory training was a blend of e-learning and classroom / on line assignments and was aligned with the Care Certificate for new staff. There was an initial three-day classroom based induction run by the provider's training manager. The Care Certificate is the government's recommended blue print for staff induction. Staff told us the training provided a good background to care and had helped them with their job role. We saw the latest training statistics for the home and found staff attendance at training was up to date. Staff told us they had also completed further training; for example, around stoma care and equality and diversity.

The registered manager informed us that some care staff had a qualification in care such as QCF (Qualifications Credits Framework). Eighty percent of care staff had such a qualification. CQF qualifications evidence a good base knowledge for care staff to carry out and maintain their care role.

Staff told us they now had regular one to one supervision sessions with their line manager. One staff told us, "[The registered manager] is very open and we can speak to him at any time but we also have regular one to one sessions with line managers for extra support." Staff we spoke with reported they were asked their opinions and felt the managers listened and acted on feedback they gave.

We found people were supported with meals and their general nutrition. Care documents contained routine assessments for any nutritional risks and we found that people who needed referral for extra professional assessment had these. We spoke with people who had put on weight since being admitted to the home.

Each person's care file included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were documented and followed through. Care records had been regularly reviewed and updated with reference to any external health support needed. We spoke with one person who told us the GP had visited because of an infection they developed. Staff had respond quickly and had been proactive regarding this. Another person had a skin condition and staff had got this reviewed quickly and always ensured the prescribed cream was applied. We spoke with three visiting health care professionals who told us the staff were quick to alert them to any issues and responded well to any instructions given in order to support people's health care needs.

We looked if the home was working within the legal framework of the Mental Capacity Act (2005) (MCA). The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
We found requirements were being met and people who lacked capacity to make certain decisions were assessed appropriately. For example, one person recently admitted had been assessed regarding their capacity to consent to the admission due to a lack of understanding. This decision had been assessed using a standard tool and evidenced the person lacked capacity to make this decision. Following admission, a referral had been made under the Deprivation of Liberty Safeguards [DoLS] for further assessment by the Local Authority.

This process showed a good understanding of the principals of the MCA and how they should be applied to ensure people's rights are protected.

We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made and people had been involved in these decisions. Most people living at the Brunswick had capacity to make their own decisions and this was evidenced throughout the care documentation.

Good

Is the service caring?

Our findings

We received very positive feedback from people being supported at The Brunswick, as well as relatives and visitors to the home, regarding the general approach and caring culture. One relative commented, "The manager and all the staff are very approachable and will always do their best to help." One person liked the fact that they were "looked after" and could not fault the care. Another person commented, "The care can't be faulted, staff are excellent."

One relative told us that staff had been so attentive and kind following admission their loved one had settled well and was now actually "Happier because they had people to mix with and staff to talk to." Another relative said, Staff are so caring – there's always a cup of tea available when you visit."

Our general observations included positive care interventions. We also carried out a specific period of observation in one of the lounges and over the morning and again at lunch time. The people involved in our observations all received support and positive interaction from staff. Staff were seen to be caring and courteous in their interactions with people.

Staff were patient and kind when responding to people's questions. Staff we observed were familiar with people's likes and dislikes. People we spoke with confirmed this, saying that they were always called by their preferred names and all felt that the staff knew them very well, apart from the agency staff.

People told us their privacy and dignity was respected. One person told us about how staff supported their choices around personal care and that they could "Have a shower every day." Staff were patient when providing support to get dressed which gave the person confidence; they said, "I'm actually happier here than I was at home." Care files contained information and assessments to show people's personal preferences were respected; for example, people were asked about whether they preferred a male / female carer to deliver personal care. There was also evidence that people had been included when devising care plans and care plan reviews had been held for some people involving the person and their family.

The manager told us about resident / relative meetings that had been arranged. Relatives we spoke with said the meetings were informative and positive. We saw the notes from a recent meeting which had been well attended. We could see from the notes that people were able to have a say about the way the home was run and that managers were open in their wish to receive any feedback.

Good

Is the service responsive?

Our findings

There were examples of staff providing care which took account of people's individual care needs. One person told us about how the door to their ensuite toilet had been fixed to make it more accessible for their wheelchair. A relative of a person living at the home said, "[Person] can do what they like. It's very flexible - when to get up and go to bed. It's very individualised. [Person] likes to take medication in the bedroom and this is [supported]."

Two people commented that "It can be a bit restrictive – we have to have staff with us if we go out and they're not always available." We discussed this with the registered manager and activities coordinator. There had been developments to the planning of activities for people with the employment of a new activities coordinator. They showed us the input they had had over the previous weeks and the activities and outings planned. The role involved interactions with people daily including people in their rooms who were unable to go to the day areas. This interaction aimed to include as many people as possible particularly ones who had not previously been involved, finding out likes and dislikes and includes relatives wherever possible.

During the morning we observed the activities co-ordinator filing and polishing female resident's nails and discussing with relative's activities they would like to be part of including morning/afternoon trips and other activities. There was a written plan for up and coming activities. On speaking with many people, they were positive with plans for up and coming activities. We discussed the importance of linking the social care plans in people's care files which listed people's interests and preferences, with the activities recorded for each person. This would further evidence a more individual approach.

People said they felt involved in their care as staff asked them regularly how they felt and whether their care needed changing in any way. People living at the home had individual care plans. These contained information and guidance for staff on people's health and social care needs, their preferred routine, daily records of the care given by the staff and input from external health and social care professionals to oversee people's health and wellbeing.

Care records we reviewed showed that people had been involved in the assessment process and planning of care. There was evidence that family members or advocates had been involved in the assessment process when needed. There was also evidence that family members had been invited to reviews of care.

We saw care plans for areas of care which included mobility, nutrition, personal hygiene, falls, people's routine, medicines and continence management. Clear and detailed care plans are important to ensure consistency of approach and to assure people's needs are met. The care plans we saw, in the main, provided this assurance particularly around people's personal care, life history, interests, daily routine and preferences – also a list of personal care tasks people needed help with. There was information about people's communication needs for instance, the need for people to have their hearing aids and glasses to aid vision as well as ensure good communication.

Care plans around people's health care needs were not always as clear; for example, one person who had a urinary catheter. The care plan was brief and ill-defined in terms of the care needed. We spoke with staff who could describe the care given in detail. The registered manager advised us that future audits would monitor health plans more rigorously.

There were no people receiving end of life care [EOL] at the time of our inspection. The registered manager reported one resident who had since passed away who received support at the end of their lives in liaison with the local palliative care team and the person's GP. Senior staff have also had a recent meeting with the palliative care ['Transform Team'] with respect to a person currently in hospital who will possibly be placed on the Gold Standard Framework on discharge to The Brunswick. None of the care team had received training in EOL care although we were told this was planned. We saw some entries in care files evidencing that any wishes at the end of people's life were being considered.

We found policies available and staff received training around equality and diversity and valuing diversity. The home had work done to the environment to ensure that it was accessible to residents with any form of physical impairment. All staff had been made aware through the training programme around the need to value people's diverse sexual identity. Information was available to staff around LGBT [Lesbian, Gay, Bi-sexual, Transgender] awareness in the elderly and a handout was available for staff to read in both the staff room and in the policy file. We discussed ways in which information could be displayed in the home to help ensure it was accessible for people.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We found the complaints policy and procedure was displayed in the main foyer and was available in an easy read format. There were good records of complaints made and these were audited and discussed at senior management level if needed.

We discussed ways in which key information could be more accessible for people, including easier formats for people to access; this was being developed with the way activities were advertised and the results of any surveys were fed back and displayed.

Good

Is the service well-led?

Our findings

The registered manager had been in post for a year since the home had opened and was seen by staff, relatives and health and social care professionals as open and positive. A visiting professional told us, "Where I have had occasion to speak to the management the concerns raised have been minor and have always been met with a positive response."

Staff spoken with also agreed that the registered manager provided an effective lead and was approachable and friendly. One staff member commented, "[Registered manager] is approachable and seems to respond well to things." Another staff member commented on the positive culture in the home which was reinforced by the registered manager's approach, "I'm very loyal to this company because they have supported me well."

The feeling on the inspection was of a positive and caring culture. The registered manager stated they felt there was a positive culture of learning at the home, particularly since the provider's own training 'Academy' continued to develop.

There was a clear management structure with defined lines of accountability. The registered manager was supported internally by a deputy and senior care staff and externally by a regional manager and quality manager who visited and supported the service on a regular basis. The providers were also based on site at The Brunswick. The Brunswick is part of a larger organisation that continues to develop. Other senior managers in the organisation included a training manager, catering manager, maintenance and estates managers, IT manager and HR manager.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The registered manager could evidence a series of quality assurance processes and audits carried out internally and externally from senior managers in the organisation. These processes and audits had been developed over several years and were now established. Over the past two years a central computerised data base – 'The Platform' - had been created which was easily accessible for all managers and provided an ongoing 'health check' of how the organisation and the various locations [services] were performing.

The registered manager explained the quality assurance framework, which consisted of daily, weekly and monthly tasks and audits to help assure good quality care. Externally the key audits were the combined monthly audits which cover key indicators such as people's finances, catering and dining experience, laundry, maintenance, pressure ulcer prevention, fire safety and care planning. Any issues raised in an action plan were then signed off as completed. A further six-monthly audit, completed by the quality managers, covered health and safety and infection control. We reviewed the latest of these during the inspection and saw they provided a good basis for analysis and monitoring.

The registered manager could show how the home had developed relationships with external commissioners and health and social care professionals. One example was when another care home closed

suddenly and The Brunswick where involved in admitting a number of people urgently. A care professional commented, "I think the home coped well with taking a number of people at the same time and supporting them to settle in and adapt to a new environment. I have found that any requests I have made in relation to supporting individuals or changing things have been actioned and I have been able to speak with the manager at any time."

The registered manager was aware of incidents in the home that required The Care Quality Commission to be notified of. Notifications had been received to meet this requirement.