

Buckland Care Limited

Brunswick House Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inspected but not rated

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Brunswick House is a residential care home. It was providing personal and nursing care to 38 people, aged 65 and over at the time of the inspection, some of whom lived with dementia. The service can support up to 46 people.

People are accommodated in one adapted building across three floors. They are provided with single bedrooms, adapted communal bathrooms and toilets and communal areas to sit and eat in. An enclosed court-yard garden provides an easily accessible outside space for people who can walk or who require a wheelchair.

People's experience of using this service and what we found

The new manager and Area Manager knew where improvements to the service were required and they were taking action to address these and improve outcomes for people. However, at the time of the inspection all the actions taken had not always been effective in addressing recording shortfalls or mitigating the risk to people till the improvements had been completed. We found more time was needed for the new manager to develop and further establish the improvements they were making and had planned to make to the service in order for the service to run smoothly and this result in consistent and effective high quality and person centred care.

Action had been taken to develop staff skills and knowledge to ensure, people's nursing needs continued to be met.

People told us they felt safe and looked after. They told us staff were friendly and kind but always busy and this meant they sometimes had to wait for staff to be available to support their wellbeing.

People's dietary needs were met. Support staff had been employed to help people access enough drinks and to support them with their meals and snacks.

People had access to medical support as required as well as other health associated services. Most people were registered with one GP surgery. A GP from that surgery maintained weekly visits to review people's health needs.

People's oral health had been assessed and when required, the care home staff organised dental support (when this had been possible during the pandemic).

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice.

Infection, prevention and control (IPC) arrangements were in place but inspectors signposted managers to specialist IPC support so they could be sure that their processes were robust and effective enough to respond to the risks posed by COVID-19.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Good (published 30 December 2020).

Why we inspected

The inspection was prompted in part due to concerns received about the quality of care provided to people. As a result, we undertook a focused inspection to review the key questions of effective and well-led only.

We looked at the home's infection prevention and control measures under the safe question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for on our website at www.cqc.org.uk.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to review our regulatory action in response to information we receive about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

At our last inspection we rated this key question as Good. We have not reviewed the rating at this inspection. This is because we only looked at the infection, prevention and control part of this key question.

Inspected but not rated

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Brunswick House Nursing Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

Two inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

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

The service had a manager who had applied to register with the Care Quality Commission and who had completed the fit person's process. They were waiting for the outcome of that process. This means that if their application is successful, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with eight people who used the service and two relatives about their experience of the care provided. We spoke with seven members of staff including an area manager, manager, two care staff, a housekeeper, head housekeeper/head cook, cook and receptionist. We spoke with one visiting healthcare professional. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included records relating to eight people's care and a selection of records relating to medicines administration, including medicines administered covertly. We reviewed records relating to processes associated with the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS). We reviewed a variety of records relating to the management of the service, including audits and the service's improvement plan.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We requested and received the provider's monitoring records for people's fluid intake and selected care records for a further seven people.

Is the service safe?

Our findings

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were somewhat assured that the provider was using PPE effectively and safely. We have signposted the provider to resources to develop their approach with the safe storage of PPE.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and health related risks were assessed in line with best practice guidance. Staff used recognised assessment tools to assess people's needs and risks in relation to pressure ulcer development, moving and handling, nutrition, weight, oral care and a sudden deterioration in health. Managers and staff described how people received care in line with these assessments.
- However, people's daily care records were sometimes inaccurate and in places incomplete. This primarily related to areas of personal care, the repositioning of people (to prevent pressure ulcer development) and the provision of fluid (drinks). One entry related to a person's wound care was not recorded contemporaneously and managers needed to explain to us that the wound had been attended to prior to when the records stated it had. This meant it was not possible for the manager and staff to always judge from people's daily care records that they had received the care they required, when they required it, or which had been planned for them.

We found no evidence that people had been harmed however complete and accurate records about people's care were not always maintained. This placed people at risk of not always receiving their care in accordance with their assessed needs. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Information about people's needs and preferences was sought prior to admission so managers could decide whether these could be met. Information about these needs were then shared with care staff in preparation for a person's arrival. Two senior care staff confirmed the manager always shared this information. One said, "Communication is good it's not been like that before, it now means I have answers for the staff when they ask."
- Information in people's care plans also described how people want to be treated as valued individuals regardless of their backgrounds, beliefs or differences.
- Technology was used to support enhanced monitoring of people at risk of falling. Sensor mats were used to help alert staff when people, who were at risk of falling, were attempting to stand or walk. Staff could then respond and provide more timely support.

Staff support: induction, training, skills and experience

- Arrangements had been made to develop staff's knowledge to ensure staff had the experience and skill to support nursing staff to meet people's nursing needs as per the conditions of the providers registration. We spoke with two of these staff who said, "It feels like a big responsibility" but who also said they were "feeling

proud" of their new knowledge and skills.

- During the pandemic staff training had predominantly been provided and maintained through online training. This had included infection control and COVID-19 awareness. More recently face to face training had been organised to extend some staffs' knowledge and skills in health-related subjects. This had included sepsis, epilepsy, wound and catheterisation care. Further subjects were booked to include, verification of death.

Supporting people to eat and drink enough to maintain a balanced diet

- Additional staff had been employed to supplement the support provided by care staff in helping people to eat and drink. The new manager was confident this had improved people's fluid intake. People's daily care records did not always show people had been provided with a drink, so at times, it looked as if they had not been. In practice we saw these staff providing this additional support.
- People were mainly positive about the food although some commented on the lack of variety and the fact there seemed to be less choice recently. One person did not enjoy the food provided so supplemented this with their own personal food preferences brought in. One person said, "It's brilliant" and another said, "It was roast pork today, there are good portions, the vegetables always seem fresh to me and most days you get a choice". We found alternatives were available, but people did not always know this.
- We observed the support people received at mealtimes. They were provided with a choice of pudding. One person told us they kept telling staff they did not want a specific food item and each time it was served on their plate. This was the case on one of the inspection days, the person was resigned to this happening so just pushed it to one side of their plate. This was fed back to the manager during the inspection.
- Some relatives visited at lunchtime to support their relative with their meal. One such visitor had noticed that their relative probably needed some help with their food and had mentioned this to the staff. They told us their relative's food was now cut up for them.
- The head cook, also the head housekeeper, had completed relevant training to be able to provide food in different textures. The kitchen staff were aware of people's swallowing assessment instructions which were provided by speech and language therapists.

Staff working with other agencies to provide consistent, effective, timely care

- Managers liaised with professionals based in hospitals and the local authority to ensure people who were medically fit to be discharged from hospital, but who required further assessment, could be admitted to the care home whilst this was organised and completed.
- Staff liaised with external healthcare professionals including adult social care practitioners, to ensure people's needs were assessed and met. For example, with occupational therapists to ensure people had the correct equipment on admission or when needs altered. Specialist mental health support was also accessed to support people living with dementia who also had associated behaviour needs. Speech and language and continence services were accessed to ensure people received appropriate assessment, treatment and aids where required.
- Staff used the services of the county's Rapid Response team. Where people required specific health support, during times of deterioration in their health and where it was in their best interests to do so, this team worked with the care home staff to provide that support in people's own homes. This avoided unnecessary and often upsetting hospital admissions for people who lived with dementia or who were on the end of life pathway.

Adapting service, design, decoration to meet people's needs

- There had been adaptations made to the building which supported people's physical needs, for example, bathrooms had bath hoists to support safer bathing. Toilets had safety grab rails to help steady people. Bedrooms and communal areas had fitted call bells so people could ring for assistance or staff could.

- A recent refurbishment of the main lounge provided people with a room to sit and socialise in which had been decorated with a neutral palette so as not to cause distress. For example, the new carpet was one soft toned colour rather than heavily patterned, which could cause disorientation to people living with dementia.

Supporting people to live healthier lives, access healthcare services and support

- People had access to medical support and review, along with access to other health related services. A GP provided an enhanced service which meant they visited the care home on a regular basis, once a week and reviewed people's health and medicines as required.
- People were also provided with regular chiropody to help maintain mobility and dental appointments could be made when required. No-one was registered with a specific NHS dentist for regular check-ups. Staff had searched for a service which provided this but had not found one. People had access to an annual review by an optician to help maintain their eyesight.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 when this is in their best interests and legally authorised under the MCA. 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.

- People who had not been able to consent to admission to the care home had been referred to the local authority for assessment under DoLS. The manager kept a record of applications made, who had authorised DoLS and the date of expiry and what if any conditions applied. This acted as an aid memoir to ensure conditions were met and reviewed appropriately and that new applications were made in a timely manner. The manager also correctly notified us as people's DoLS applications were authorised.
- Processes were in place to ensure decisions made on behalf of people who lacked mental capacity, were made in their best interests. These processes had been followed for decisions needed to be made about people's care and treatment.
- Records were in place recording best interest decisions for administering medicines covertly (hidden in food or drink) to people who required prescribed medicines to maintain their health and wellbeing but who could not provide consent for these to be administered. Covert administration of medicines was only used when people consistently refused to accept their medicines, and this would have a negative impact on their health.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

We found more time was needed for the new manager to develop and further establish the improvements they were making and had planned to make to the service in order for the service to run smoothly and this result in consistent and effective high quality and person centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had systems in place to monitor the service's overall performance. A new provider representative (Nominated Individual - NI) had started in post and they had visited the service but not yet completed a full audit on behalf of the provider. The NI is responsible for the management oversight of the service on behalf of the provider.
- The new manager and Area Manager knew where improvements to the service were required and they were taking action to address these and improve outcomes for people. However, at the time of the inspection the action taken had not always been effective in addressing shortfalls or mitigating the risk to people till the improvements had been completed.
- Systems used to monitor quality in the service was not always effective as the information relied on was at times incomplete or inaccurate. The manager created reports from the service's electronic records system to monitor daily care delivery; this included reports in relation to people's fluid intake. The information in these reports about people's daily fluid intake did not correspond with some entries in people's care records, which were either sometimes inaccurate or incomplete. This made it difficult for the manager to accurately monitor what fluid people had been offered and consumed when monitoring people's hydration.
- The manager had identified the same problem when monitoring people's repositioning care and had instructed team leaders to monitor this and raised this in staff handover meetings. Again, people's care records we looked at in respect of this were either not always accurate or complete and in places it would not be possible for the manager to determine a clear audit trail of the care delivered to people.
- Action taken to improve the service were not always effective. People had been admitted and not registered with a GP in a timely manner so that a fresh stock of medicines could be prescribed and delivered. One person had gone without their medicines for one day because of this delay. Despite the manager putting a member of staff in place to ensure people's monthly medicines were ordered, prescribed and delivered, repeated problems had occurred with the ordering of people's medicines who were discharged from hospital with a limited supply. Processes put into place to address this issue and to monitor this had not been effective in preventing this from reoccurring.

- Infection control audits were not sufficiently comprehensive to ensure shortfalls in relation to COVID-19 specific guidance such as the use of personal, protective, equipment (PPE) would always be identified.
- An effective system had not been in place to support the manager to have oversight of staff supervision, to ensure it would be completed when required. The manager had completed some staff supervisions but had not yet had time to review all staff files to establish who still required supervision.

We found no evidence that people had been harmed however, systems were either not robust enough or effectively operated to demonstrate safety and quality was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had devised a new staff supervision matrix. Once fully completed with the necessary information, this will help them have oversight of which staff have been provided with appropriate supervision and which staff still required this.
- We found progress had been made to address other shortfalls identified by the manager and Area Manager. This included recruitment of support workers and an activities co-ordinator after an absence of several weeks without one. A maintenance person started in post and was starting to address some of the improvements required.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The new manager worked in an inclusive way, always attended staff handover meetings and was promoting a person-centred approach to care. A healthcare professional commented that the manager's knowledge of the service users was 'exceptional'.
- The Manager supported senior staff to feel empowered in a time when they were needing to 'step up' and replace nursing colleagues. They operated an open-door policy and made sure they were visible around the care home.
- They were keen for staff to feel valued not only to support staffs' mental wellbeing during a difficult time, but also to reduce the high staff turnover experienced in the last year. A scheme had been re-instated where nominations were made for employee of the month with the nominated staff member receiving a small gift of appreciation."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care.

- Both the manager and Area Manager understood their legal responsibility in relation to duty of candour. There had been no incidents which had needed to be reported under duty of candour.
- Appropriate notifications had been made to us to support our monitoring of the service.
- When feedback or concerns had been received the new manager had addressed these in an open and transparent way recognising when lessons needed to be learnt from dissatisfaction or when things had not gone to plan.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People's views and ideas had been asked for in the planning of the refurbishment of the courtyard garden. This was to have newly raised borders and a sheltered area for sitting away from the rain or sun.
- Arrangements were in place for people and relatives to 'have their say' so feedback about the service could be gathered. The provider had organised an annual satisfaction survey and had received predominantly positive results back from relatives, service users and staff, in August of this year. We

reviewed the feedback received. Where this had indicated a need for improvement in the services provided or where clarification had been required, an action plan had been implemented in response to this feedback and was currently being acted on.

- The system of 'resident of the day' had been introduced to specifically focus on gathering feedback from people who have resident of the day status and to ensure this was acted on (where possible) and to fully review the person's care and preferences with them and in line with their protected characteristics.

Working in partnership with others

- Staff had been keen to make new community links, but the pandemic had limited progress with this. A recent new communication with a cat rescue charity had provided an opportunity for cats to visit people in the care home, which was enjoyed by many.
- A link had been made with a local church which had enabled one person to receive a regular visit from the Vicar which supported their religious preferences and wishes.
- Staff were in regular contact with local authority commissioners to support necessary admissions and to ensure any safeguarding information was appropriately shared.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Governance systems were either not robust enough or effectively operated to demonstrate safety and quality was effectively managed. Regulation 17 (1) (2) (a) (b).</p> <p>Accurate, complete and contemporaneous records were not always being maintained of the care and treatment provided to people in order to demonstrate that people had been provided with the care they required.</p> <p>Regulation 17 (1) (2) (c).</p>