Bruno's Care Limited

# Bruno's Cottage

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Bruno's Cottage is a residential care home registered to provide accommodation with personal care for up to six people with a range of needs including people with learning disabilities and people on the autism spectrum. There were seven people living at the service at the time of inspection.

People's experience of using this service and what we found
The service rarely applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

People's experience of using this service and what we found
The leadership and the management of the service was ineffective. The provider and registered manager did not have sufficient oversight of the service to ensure people received the best possible care.

Audits had not identified issues regarding medicine recording, care plans and risk assessments not being up to date and relevant to the person. This put people at risk of serious harm.

Audits had not been completed for infection control and water temperatures.

Not all staff working with people had the necessary training to support them safety. Care plans and risk assessments were not kept up to date and relevant. When incidents or accidents occurred, these had not always been reviewed and any lessons learnt had not been identified or acted on. This put people at risk of harm that could have been avoided.

Medicine records were not always completed with all the information required. People had not been consistently safeguarded from abuse.

People were subject to high levels of control and restrictions from staff. This resulted in people not always being treated in a dignified manner. Their privacy was also affected by some of the control measures in place.

The environment had not been kept in a clean and hygienic state. We found issues relating to infection control.

The provider and registered manager had not kept the Commission informed of any changes to their registration or of notifying us of events they are required to by law.

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 8 August 2017). The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Why we inspected
We received concerns in relation to the number of people living at the service, and how the provider met the needs of people with complex behaviours. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led.

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

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

Enforcement
We have identified breaches in relation to keeping people safe, protecting people from unsafe or improper treatment, cleanliness of the environment and systems and procedures at this inspection.

We have also identified breaches relating to the providers registration with the Commission.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Details are in our safe findings below

### Is the service well-led?

**Inadequate**

The service was not well led.

Details are in our well led findings below

# Bruno's Cottage

**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.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Bruno's cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 registered with the Care Quality Commission. This means that 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
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection

During the inspection
We observed the interactions between staff and people living at the service and spoke to one person who used the service. We spoke with six members of staff including the director, registered manager, assistant manager and care workers.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate: This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse. Using medicines safely

- Systems and processes were not in place to protect people from harm. For example, staff had completed a physical intervention with a person without receiving training relating to this intervention. Therefore, people were at risk of disproportionate restraints which could result in injury or harm.
- One person's care plan identified a need for a physical restraint technique that staff were not trained to complete. Therefore, staff could not follow the care plan to keep the person safe.
- People were subjected to significant levels of control and restriction. For example, one person's care plan stated, 'If I have done something more serious and unacceptable, I may need to be sanctioned." Another person's incident record evidenced that staff told them "to go to their room and think about their behaviour."
- One person did not have a bedroom of their own, they were sleeping on a sofa in the lounge while another person stayed in their bedroom. We saw people coming in and out of the lounge when the person was asleep.
- Medicines administration record (MAR) were not completed consistently. We found that for two people who were prescribed as required medicines, their records did not identify the reasons staff gave the medicines. This meant that people were at risk of being given their medicines more frequently and not as intended.
- When people required cream applied, records did not have detailed information on where the cream should be applied.
- Not all staff who administered medicine had their competencies checked regularly. For example, two staff hadn't been reassessed in five years, another three staff hadn't been reassessed in three years. Best practice guidelines suggest staff being checked yearly.

The provider failed to ensure that people were protected from abuse and improper treatment. This is a breach of Regulation 13(1) Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Assessing risk, safety monitoring and management. Learning lessons when things go wrong

- The provider had not ensured all the relevant information was in place and that potential risks to people had been identified. Therefore, people were at risk of harm.
- People were not protected against the behaviour of others. For example, we saw that one person had harmed other people living at the service on six occasions within a period of eight weeks and harmed staff on eight occasions within a period of six weeks. These incidents had not been investigated or reviewed. This meant the registered manager was unable to evidence they had analysed for any themes or trends.

Therefore, no measures were in place to reduce the risk of similar incidents occurring.
● One person demonstrated behaviours which were a risk to children both in the service and in the community. Their risk assessment did not identify strategies to keep children safe and we saw incidents continued to occur. This meant children continued to be at risk of harm. The registered manager had not reviewed the events to ensure strategies were in place and any lessons were learnt were shared.
● One person who was at high risk of falling from a height, did not have a risk assessment completed regarding residing on the first floor and any risks associated with being able to get out of the bedroom window.
● Risk assessments did not always identify the current risks for people. For example, one person's risk assessment recorded a low risk of self harm, however within daily notes we saw there had been an increase to behaviours associated with this risk. The risk assessment had not been updated.
● Staff had not consistently recorded or evidenced that water temperatures had been checked when people had a bath or shower. Weekly and three-monthly water temperature checks evidenced that hot water was above the recommended temperature to protect people from scalding. Therefore, people were still at risk from scalding.

The provider had not ensured all the relevant information was in place and that potential risks to people had been identified. Therefore, people were at risk of harm. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Preventing and controlling infection
● People were at risk of health problems and infection risks due to the overall cleanliness of the environment.
● We saw areas of the home that had mould on the windows, faeces on a door handle and kitchen cupboards that were stained and dirty.

The provider failed to ensure that the premises and equipment used were clean, secure and properly maintained. These concerns constitute a breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: premises and equipment.

Staffing and recruitment
● The provider followed safe recruitment procedures. Records confirmed that Disclosure and Barring Service (DBS) checks were completed and references obtained from previous employers. These are checks to make sure that potential employees are suitable to be working in care.
● Staff did not always receive regular supervisions. We saw no evidence of spot checks being completed or feedback to staff regarding their performance.

Inadequate

# 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 Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- People were at risk of receiving unsafe, poor quality care due to the lack of oversight of the service, records and practices.
- Systems to ensure the safe and effective running of the home were not effective. Audits were not always completed and therefore had not identified concerns with medicine records, water temperature checks and cleaning schedules. Therefore, no action had been taken and this placed people at risk of harm and on occasion at risk of serious injury.
- The systems in place to review and monitor people's care plans and risk assessments were ineffective. People's risk assessments and care plans contained conflicting information about areas of risk in their lives. Risk assessments were not fully completed.
- The registered manager had not identified the need for all staff to be trained in physical intervention to safety support people living at the service. This put people at risk of harm from inappropriate restraints.
- People were at risk of harm as opportunities to learn from incidents had been missed. Some incident records had not been reviewed. When incident records had been reviewed, actions planned to reduce the risk were not appropriate and were ineffective.
- A person who was at risk of 'absconding' had no documented measures in place to prevent this or to share information should they go missing.
- The lounge where a person slept did not have any curtains or blinds fitted on the windows. This meant the person did not have any privacy, we saw no actions plans to rectify this issue.

The provider failed to ensure that that their systems and processes were established and operated effectively to improve the service provided to people. These concerns constitute a breach a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

- The registered manager and provider did not understand the regulatory requirements regarding submitting statutory notifications to the Care Quality Commission (CQC). This meant they had not informed the CQC when serious incidents or safeguarding concerns had occurred.

Failure to notify the Commission constitutes a breach of Regulation 18 of the Care Quality Commission

(Registration) Regulations 2009 (part 4): Notifications of other incidents.

● The registered manager and provider had agreed to support more people than they were registered for. This put people at risk of harm as the service could not accommodate all of the people they supported. For example, one person did not have a bedroom and had to sleep on the sofa in a communal area of the home.

The provider failed to meet the requirements of their registration with the Commission by supporting more people than they were registered for. This constitutes a breach a breach of Regulation 33 of the Health and Social Care Act: Failure to comply with a condition.

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

● People had not been supported to share their views on the care they received since 2017. However, people had keyworkers who they met with regularly.

● Staff meetings were held, however the last staff meeting recorded was five months old.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to ensure people's risks were being assessed and managed appropriately. |

**The enforcement action we took:**

We imposed conditions on the registration to restrict admissions to the home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider failed to have suitable systems in place to protect people from potential abuse or improper treatment.<br>The provider failed to assess and plan for the delivery of safe care. |

**The enforcement action we took:**

We imposed conditions on the registration to restrict admissions to the home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider failed to ensure infection control measures were in place. |

**The enforcement action we took:**

We imposed conditions on the registration to restrict admissions to the home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to ensure that incidents affecting people were reviewed, investigated and monitored.<br>The provider failed to have adequate systems in |

place to monitor the quality care being provided.

**The enforcement action we took:**

We imposed conditions on the registration to restrict admissions to the home.