Borough Care Ltd

Bruce Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bruce Lodge is a care home which provides accommodation and personal care for older people, some of whom live with dementia, and was supporting 39 people at the time of inspection. A new unit had been built, and once this unit was open, the service can support up to 67 people. People had their own bedrooms and access to various communal areas and secure outside garden.

People's experience of using this service and what we found
People's needs and risk were assessed but records were not always consistent and detailed. People felt safe but there was not always enough staff to meet their needs quickly. We have made a recommendation about staffing levels. People had their medicines as needed, but records lacked detail about how to support people with medicines that they needed occasionally, or which were given covertly hidden in food or drink. We have made a recommendation about the management of some medicines. Work was ongoing to ensure lessons were learnt from accidents, incidents and safeguarding concerns.

There was a new registered manager and operational management team in post. They completed a variety of checks to ensure the quality of the service and were working through a range of actions as part of the service improvement plans. People spoke positively about the registered manager and felt able to raise concerns with them. The registered manager worked with other health care services to ensure people's needs were met and they were committed to driving improvement within the home.

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 17 June 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the management of falls. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key 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 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 comprehensive 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.

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

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bruce Lodge

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
The inspection was carried out by two inspectors on the first day of inspection and one inspector on the second day.

Service and service type
Bruce Lodge 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 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 on both days of inspection.

What we did before the inspection
We reviewed information we had received about the service since it was last inspected. This included information from the service about events they are required to tell us about and information received from people who had shared their experience of care with us. We sought feedback from the local authority and professionals who work with the service. The provider did not complete the required Provider Information

Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with 14 members of staff including the register manager, deputy managers, nominated individual, senior care workers, care workers, and auxiliary workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with three relatives to gain their views on how their family members were supported at Bruce Lodge during our site visit. We spoke with two visiting professionals about their views of the service. We observed how people were being supported during the day and walked around the service to ensure it was clean and a safe place for people to live.

We reviewed a range of records. This included seven people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and reviewed additional information provided by the service. We contacted additional staff and relatives to obtain further feedback.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● There were not always enough staff to meet the needs of people quickly. We observed that staff were very busy, not always able to respond to requests for assistance promptly, and people were left without staff support in communal areas for varying amounts of time.

● Feedback from people, professionals and staff confirmed that there were times when there was not enough staff. One person told us, "Staff come to help, but sometimes I have to wait for care." A professional commented, "The staff are always friendly, and there are good interactions [between staff and people] but they need more staff." Relatives were not able to comment on staffing levels within the home, but all commented that their family member was well looked after. Most staff commented that there were not enough staff with one telling us. "It is difficult to have oversight; we need more staff."

● We spoke to the registered manager and nominated individual about staffing. They assured us that plans were in place to recruit additional staff, but the service was facing several challenges in this area. We will review how these challenges have been overcome, and whether people are supported by enough staff at the next inspection.

We recommend that the provider continue to review staffing levels robustly, considering a variety of factors, to ensure there are enough staff to meet people's needs.

● People were supported by staff who had been suitably recruited. The service completed checks of staff's character and experience before they began working with people living at Bruce Lodge.

Using medicines safely

● People were supported to take their medicines as needed. Medication administration records indicated that people were being supported to take their tablets although we found some shortfalls in the counts of medication which we were not able to account for and raised this with the registered manager to complete their own investigation.

● Medication administration records did not always contain enough detail about how and when to give people certain types of medicines. This included medicines that people needed 'as and when', such as paracetamol for pain, and medicine which needed to be given covertly, hidden in food and drink. We spoke to the management team and were assured that the necessary improvements for medicines records would be made.

● The provider had checks to ensure that people received the support they needed with medicines. These checks had identified some shortfalls and we noted that some of these issues had been addressed but other areas were still being implemented and embedded. We will review this at our next inspection.

We recommend the provider ensures that good practice guidance is implemented to ensure people are safely supported to take their medicines.

Assessing risk, safety monitoring and management
● People's needs and risks were assessed and staff understood how to support people. However, care plans were inconsistent in how and where information about the management of risk was recorded. Not all care plans contained enough person-centred detail to guide staff on how best to support people.
● People were supported with a range of equipment to reduce the risk of incidents and accidents, such as technology to alert staff when people were moving. Processes were in place to ensure all equipment was working and the registered manager had completed work with families to implement the use of an 'acoustic monitoring' system with the aim of reducing the risk of unwitnessed falls.
● People were supported to access appropriate services when risk was identified. People who had fallen were supported to access medical treatment when needed, the GP was asked to review people's medicines and referrals to the falls team were being made. However, accident reports did not always capture important information, and risk assessments and care plans did not always show what else was being done to reduce further risk.
● The registered manager and management team had identified there were areas for improvement regarding how risk was assessed and managed. They were in the process of implementing and embedding systems to ensure people's needs were effectively managed through detailed care plans and clear policies and procedures.

Systems and processes to safeguard people from the risk of abuse
● People felt safe at the service. One person told us, "I know who to speak to if I'm worried, and I am safe here."
● One staff member commented, "I think people are safe here, staff know them well and work hard to ensure people are well looked after." We observed that people were supported by staff who were kind and caring.
● Staff had completed training in this area and understood their responsibilities to safeguard people. Staff felt able to report concerns to the team leaders, deputy managers and registered manager.

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 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.

Learning lessons when things go wrong
● Processes were in place to enable lessons to be learnt when things had gone wrong. The service had several forums to discuss people's needs, ensure appropriate action had been taken and share good practice. This included falls meetings and health and safety meetings.
● The service had identified resources to support good practice. People received support from health care

professionals such as opticians and GPs. Other examples of good practice included the use of exercise programmes for people to build strength and aid balance, and access to advice and support from services such as 'Steady in Stockport' and 'Cosy toes'. Work in this area was ongoing and we will assess the impact of this at our next inspection.

Requires Improvement

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.

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

- People's care plans were not consistently person-centred and detailed. The registered manager completed checks of care records and had identified these shortfalls but work in this area was still ongoing.
- Staff felt well supported in their role. One member of staff told us, "We've had lots of manager changes, but the new manager and deputy seem nice. They do listen to us and we have regular meetings."
- People looked well cared for and those able to, told us they were happy. A range of group activities were available for people, although staff were very busy and not always able to offer activities and stimulation for people who did not wish to engage in groups.

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

- The new registered manager and operation team completed a variety of checks and audits to ensure any issues were identified and addressed, and to drive improvement within the home. These showed recently that issues were being identified and action taken to learn lessons. However, assurance is needed that current changes made in the service are effective to ensure good quality care is sustained.
- The registered manager and operational team investigated and responded to formal complaints. This included offering an apology when appropriate.
- The service had implemented new systems to monitor accidents and incidents. Work was ongoing to ensure a consistent approach to recording, monitoring and responding to these. We will review this at our next inspection of the service.

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

- People and families spoke positively about the registered manager and staff. One person told us, "The manager is pleasant, and they all care how we are doing." One relative told us, "Since the new manager arrived, we have felt more assured than ever before. They are very proactive and contact us if there are things we need to know. They have given up time to carry out care plan reviews with us as a family." Another relative told us, "I can speak to the registered manager about concerns and they will see what they can do. The staff manage my [family member] well and with the new manager things seem to be getting back on track."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and relatives were encouraged to share their views. The registered manager would speak to people living at Bruce lodge regularly and took opportunities to obtain people's views on the home.

● The registered manager had worked to develop relationships with people's relatives and started a virtual relatives meeting which was used to update relatives and obtain views and ideas about how to improve. One relative told us "I feel able to raise concerns and I've spoken to the manager a couple of times. I can drop them an email and they always respond."

● The service worked closely with a variety of healthcare professionals. When people's needs changed additional assessments and advice was requested from services, including district nurses, GP's and dementia specialists.