Buckland Care Limited

Brunswick House Nursing Home

Inspection report

119 Reservoir Road
Gloucester
Gloucestershire
GL4 6SX

Tel: 01452523903
Website: www.bucklandcare.co.uk

Date of inspection visit:
20 February 2018
22 February 2018

Date of publication:
02 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 20 and 22 February 2018.

Brunswick House Nursing Home is registered to provide nursing and residential care for up to 46 people. Accommodation is provided in one adapted building. 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. Brunswick House is for older people who may be living with dementia. Care is provided on a long-term or short-term basis, with some people admitted for respite or further assessment on discharge from hospital. At the time of this inspection 42 people were living at the home.

Accommodation at Brunswick House is provided over three floors with bedrooms located on the ground, first and second floors. All floors were wheelchair accessible, with upper floors being accessed via the lift or stairs. Most bedrooms had en-suite facilities and adapted communal bathrooms were available to all. Lounge / dining rooms were located on the ground and first floor. A small garden was accessible from the conservatory / dining area on the ground floor.

Brunswick House Nursing Home was last inspected in April 2016. At this inspection, the home was rated "Requires Improvement" in the Safe domain, as minor improvements were needed in records relating to medicines management. No breaches of regulations were identified. Brunswick House was rated Good overall at this inspection and an action plan was not required.

This inspection was brought forward in response to concerns raised to us in February 2018. This information suggested required standards may not be being met. We therefore wanted to review the care and treatment provided to people.

The service had a registered manager. 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. The registered manager had been in post as manager of the home since 2003. They were registered with CQC as manager of the home in 2011.

During this inspection we identified five breaches of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014. Regulation 12 Safe Care and Treatment was not met. Improvements were needed to ensure risks to people were managed safely. This included safe use of equipment, adherence to safe moving and handling practices, ensuring staff followed the guidelines in place and managing people's medicines safely. There were enough suitable staff to meet people's needs. The building and equipment were appropriately maintained and people were protected from risks associated with cross infection.

Regulation 13 Safeguarding service users from abuse and improper treatment was not met. People were not

always protected from improper treatment as requirements to obtain authorisation to deprive people of their liberty were not always followed.

Regulation 18 Staffing was not met. People were not always supported by staff whose skills and competency to carry out their duties had been suitably checked.

Regulation 9 Person-centred care was not met. People's needs were not always assessed promptly and detailed care plans were not always in place to ensure people's needs and preferences would be met. Staff worked well with external health professionals to meet people's health needs and supported people to eat a suitable diet.

Regulation 17 Good governance was not met. The systems and processes in place to monitor the safety and quality of the services provided to people were not always effective in identifying and addressing shortfalls. Complete records of the care and treatment provided to people had not always been kept. People's views about the service they received were sought and these were used to improve the service people received.

People received support from caring staff. Their privacy was respected and they were treated with dignity and kindness. People were supported to maintain relationships with others who were important to them. When people's preferences were known to staff, these were respected and people were offered choices in their day to day lives. People received suitable end of life care.

This is the first time the service has been rated Requires Improvement. You can see what action we told the provider to take at the back of the full version of the report.

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.

Risks to people's health and wellbeing were not always managed safely and risks to people were not always reviewed following an incident/accident.

Improvements were needed to ensure people's medicines were stored and managed safely.

There were enough staff to meet people's needs.

Suitable recruitment systems were in place to recruit new staff.

Staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Some people had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority or application to the authorising authority having been made.

People were not always supported by staff whose skills and knowledge to meet their needs had been checked effectively.

People's needs were not always assessed promptly and detailed care plans were not always in place to ensure people's needs and preferences would be met.

People's health and nutritional needs were met and they had access to health and social care professionals.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, caring and supportive.

People were treated with respect and their privacy and dignity

and privacy was maintained.

People were able to express their views and their independence in daily activities was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were needed to ensure people received personalised care.

People had access to a variety of activities in the home and their local community. People were supported to maintain relationships with those who mattered to them.

People were able to raise complaints and these were investigated in accordance with the provider's policy.

People received appropriate end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems were in place to monitor and make improvements to the service were not sufficiently robust to identify and address all required improvements.

Complete records of the care and treatment provided to people had not always been kept.

The provider and management team worked openly with others, seeking their feedback, to improve the service. We received mixed feedback about the culture and leadership at the home.

Brunswick House Nursing Home

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 was planned to check 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 inspection was brought forward in response to concerns raised to us in February 2018. This information suggested required standards may not be being met.

This inspection took place on 20 and 22 February 2018. The inspection was unannounced and was carried out by two inspectors, an inspection manager 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. Their area of expertise was dementia. Two inspectors and an expert by experience visited, unannounced, on the first day of the inspection. The second day was announced and was carried out by one inspector and an inspection manager.

Before the inspection, we reviewed information we held about the service including notifications. A notification is a report about important events which the service is required to send us by law. A Provider Information Return (PIR) was not requested prior to the inspection. This 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. This information was gathered at the inspection. We gathered the views of two health care professionals, an environmental health officer and commissioners. Throughout the inspection we observed the support being provided to people. 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 also spoke with seven people who use the service and a relative. We reviewed nine people's care files which included pre-admission assessments, care plans, risk assessments and documents relating to assessment of mental capacity and Deprivation of Liberty Safeguards (DoLS). We attended two staff

handovers.

We spoke with a representative of the provider, the registered manager and their deputy, the clinical lead, four nurses, one team leader, four care assistants, the head chef, maintenance person, three housekeepers and the activities co-ordinator. We checked medicines records and observed two staff members administering medicines. We reviewed the processes in place for managing medicines, including the use of 'as required' medicines and medicines with additional storage and recording requirements. We looked at recruitment records for four staff, staff training and supervision records, complaints and accident and incident records. We checked maintenance records, discussed provider policies risk assessments for fire and legionella and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Risks to people were not consistently assessed or reviewed to ensure risk management plans gave staff the information needed to keep people safe. Some support plans lacked relevant details and where risks had been identified, staff did not always support people to reduce these risks.

Two people who required assistance to move told us staff supported them to remain safe. One said, "I have to use a Sara Steady (standing aid) which requires two people. The staff manage this OK.'' Staff had received moving and handling training. However, we observed that staff did not always adhere to safe moving and handling practices. In particular, some staff were observed supporting people under the armpit or holding onto people's upper arm during transfers. For example, when using a Sara Steady, a staff member put their hand in the person's armpit and pulled them upwards. This could potentially cause injury to the person.

Two people required a pureed diet and thickened fluids to reduce the risk of them choking or inhaling fluids. In one case we saw the support plan was being followed by staff, but in the second case we had to intervene to reduce risks to the person. At lunchtime on the second day of our inspection, we found staff had not thickened a person's drink to the required consistency, as recommended by their Speech and Language Therapy assessment. No thickener was added to the person's drink until we explained our concerns to the staff member, where upon they acted immediately. At our request, an immediate action plan was provided by the registered manager to reduce this risk. We observed staff respond safely when a person's food "went down the wrong way", almost causing them to choke. Emergency procedures were followed by staff as a precaution and the potential emergency was averted in a calm and reassuring manner.

On two occasions we observed metal bed rails (the type which are not part of the original bed frame) in use. These had protective 'bumpers' in place, which had become displaced. Bumpers are sometimes used to reduce potential injury to people's limbs when bed rails are in use. We observed one person who had their leg trapped under the bed rail and we sought immediate assistance from staff. The staff member attending told us, "It's normal for [person's] leg to be down the side like this." Daily care records showed this person had been found with their leg through the bed rail twice before in the preceding two weeks. No action had been taken at the time to avoid this happening again and to prevent further injury.

A relevant care plan also recorded this person liked to use the bed rails to help move themself in bed. Guidance in relation to the safe use of bed rails and on the risks posed to people using bed rails, for this purpose, has been issued by both the Health and Safety Executive and the Regulating Medicines and Medical Devices (MHRA). This guidance clearly states bed rails are not designed to be used in this way. We shared our concerns about this with managers on the first day of the inspection. When we returned, a new risk assessment for use of bed rails had been completed for this person; the bedrails had been removed and an alternative solution was being trialled. A member of the management team told us this type of bed rail was to be removed from use at the home.

At our last inspection we found accurate records had not always been kept in relation to people's medicines, which the registered manager acted immediately to address. Prior to this inspection, the provider had

introduced an electronic medicines system with built in safety features. Despite this improvement, we identified some concerns in relation to the administration and storage of medicines.

Storage temperature checks were not always carried out. Medicines not stored at temperatures recommended by the manufacturer can potentially lose their optimum effectiveness. Not ensuring correct temperatures are maintained can potentially affect people's health. Topical medicines records were not completed consistently and guidance for staff in use of 'as required' medicines were not always in place. GP agreements were in place for the use of 'homely remedies' for some people. However, these had been used for people where an agreement was not in place.

An experienced staff member told us giving medicines was difficult at weekends, as the electronic system was time consuming. At weekend's only one member of staff able to administer medicines was on duty each shift. As a result, two people had not received one of their medicines as prescribed during the previous weekend. These shortfalls increased the risk of people not receiving their medicines as prescribed. Our observations of medicines administration also revealed shortfalls in one staff member's practice, which we reported to the registered manager.

The above practices demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people were managing their own medicines and told us they were satisfied with their medicine arrangements. Other areas of medicines management checked by us, such as additional storage and records, were found to be managed appropriately.

Staff involved other health care professionals appropriately and promptly when people's health altered. Staff acted on their advice, which was communicated to other staff effectively. Health professionals, who visited the home regularly, said they had no concerns about care provided at the home. One told us, the last time they could recall a person at the home having a "bad pressure sore" was a "good few years ago". They had not observed any poor moving and handling practices and said Brunswick House, "compares well to other homes."

Personal Evacuation and Egress Plans (PEEP) were in place for each person, indicating the level of support they would need to evacuate the building safely. However, these plans needed to be updated to reflect people's current needs. Regular checks and maintenance had been carried out to maintain the safety of the building.

Staff completed records of incidents and accidents, including any unexplained bruising and falls. A monthly summary was produced and an analysis of this information enabled trends to be identified and responded to.

People were protected from the risk of abuse. Staff understood their responsibilities in relation to this and they followed the processes in place to safeguard people. Staff understood how to recognise signs of abuse and were confident that managers would take their concerns seriously. All staff had received training in safeguarding adults. Where allegations of abuse, including neglect, had been raised, the provider had correctly informed the local authority and the Care Quality Commission (CQC).

Staff recruitment records showed that safe recruitment processes were followed. This protected people from those who may be unsuitable. A probationary period allowed managers to review the suitability of new staff members.

The registered manager ensured there were enough staff on duty to meet people's needs. Whenever possible, staff who were regularly employed at Brunswick House covered shifts, rather than using agency staff. A nurse was on duty at all times. Checks were carried out of call bell response times, which showed staff were responding to people's requests for assistance in a timely manner. People we spoke with were satisfied with the response times. Comments from people included, "Responds quickly to the bell" and "Oh yes, they come within minutes of my pressing the bell". We saw staff responding quickly when people rang for assistance.

We saw that people lived in a clean home which was free of malodours. The cleaning staff explained how they kept the home clean and what records they completed. One person said, "[The] cleaner comes every day and will take my laundry if I want them to" and a relative said the home was "Clean and hygienic." Colour coded cleaning equipment minimised the risk of cross infection. Staff understood their responsibilities regarding infection control. When we spoke with care workers they demonstrated a good level of knowledge on appropriate infection control practices. One said, "I make sure I am always wearing my gloves when providing personal care.''

Requires Improvement

Is the service effective?

Our findings

Some people living with dementia did not have the mental capacity to independently make decisions about their care arrangements. 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 who lack capacity to consent to their care can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care and nursing homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and had applied for the necessary authorisation when depriving a person of their liberty.

Staff had received MCA training and were able to demonstrate that they understood the issues surrounding consent. However, in some cases the provider had not obtained consent to care in line with the Mental Capacity Act (2005) (MCA). People's rights and liberty had not always been protected when care and treatment arrangements were made to keep them safe. Some people, who could not consent to restrictions being placed on them, to keep them safe, were being deprived of their liberty without appropriate safeguards in place. Senior staff were aware of the process for seeking authorisation to lawfully deprive people of their liberty under DoLS, where this was in their best interests. We saw examples of DoLS authorisations having been requested and granted in some people's files. However, DoLS application had not been made for eleven people who could not consent to living at the home. During our inspection the registered manager started taking action to ensure the required DoLS applications were submitted.

People had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority or application to the authorising authority having been made. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The registered manager told us and staff confirmed they completed training as part of their induction as well as on-going training. A senior carer told us, "When new staff come in I train them up." Records confirmed that staff had completed mandatory training in various topics including safeguarding adults, moving and handling, infection control and dementia care. Nurses had received training in medicines administration and had also undertaken specific training relevant to people's specific needs, for example diabetes care, syringe driver use and catheterisation .

Whilst training was available it was not effective in all cases and staff did not always have the skills or knowledge to support people effectively. We found some practice concerns in supporting people to move safely, when assisting people at risk of choking and when staff administered people's medicines. For example, when administering medicine, a staff member did not consistently stay with people to check they had taken their medicines to ensure they received their medicines as prescribed. The registered manager

told us staff had just completed training in bed rails however we found this had not been effective in ensuring staff were able to identify the bedrail concerns we found prior to our inspection. Two staff we spoke with did not know that a person at risk of choking required thickened fluids as noted in their risk assessment and had therefore not prepared their drinks correctly. We asked an experienced care worker how they knew, for example, what size sling a person needed (when using a hoist) they relied, "Usually you can tell by looking at them [person] whether it's medium or large." Guidance in relation to the safe use of hoisting equipment and the potential risks posed to people has been issued by the Health and Safety Executive. This guidance clearly states, "There is a risk of using an inappropriately sized sling if you make assumptions without checking the suitability of a specific sling for the individual."

The registered manager told us they checked staff competency through supervision as well as working alongside staff to observe their practice. The supervision matrix confirmed staff had received supervision. However, recorded competency assessments were not routinely completed to ensure staff could safely perform practical care tasks like moving and handling, mealtime support and wound care in line with good practice guidelines. For example, one nurse told us their competency to give medicines safely had been checked when they started working at the service, several years earlier but not since and another nurse told us their competency had not been checked. Staff had therefore not been provided with an opportunity to review their leaning and development needs in practice and for their manager to appraise their performance. The registered manager had therefore not identified the practice concerns we found and that additional skills and knowledge might be required for some staff. There was a risk that staff might not be able to always fulfil the requirements of their role.

Training and supervision had not always been effective in ensuring staff had the skills and competency to support people effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When assessing people's needs, staff used universally recognised assessment tools that took into account nationally recognised evidence-based guidance. However, we found these tools had not always been used promptly following admission, or as people's needs changed. This meant the outcomes of evidence based assessments were not always available to inform discussions with people about the care and treatment they required. This placed people at risk of not receiving effective care that met their needs and preferences. For example, a person whose care we tracked was admitted to the home in January 2018. A pressure area assessment (using the Braden Scale) and a mobility assessment was first carried out 12 days after admission. A malnutrition (MUST) screening was first completed when they returned to the home from hospital, a month after moving into Brunswick House. The person was then being nursed in bed and a moving and handling plan and mobility care plan were put in place. Despite these formal assessments not having been completed, it was evident that action had been taken to manage these risks to the person.

Another person had been admitted from hospital, three weeks prior to the inspection. They had been weighed but a MUST score hadn't been calculated and a nutritional care plan had not been completed. These were needed to ensure they would remain sufficiently nourished: Taking into account times of the day they liked to eat, what snacks they preferred, whether they needed assisted cutlery or assistance from staff to eat. This person told us, "I don't like the food." Another person commented, "Today there was a choice of beef casserole or sausage and mash. I chose the sausages because if I had the casserole it would be all over the place. I can't manage sloppy food. There's nobody to help and I don't like to ask." There were enough staff available to help, had this person's need been known to staff.

People's needs had not been assessed promptly and detailed care plans were not always in place to ensure people would receive individualised care. This was a breach of regulation 9 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

People's diverse dietary needs were met. Comments included, "They accommodate very well with my very complex diet." This included ensuring people with allergies did not miss out on treats. Meals were prepared using fresh and frozen ingredients and people were given a choice of two alternatives at each meal. Staff attended to needs of people who needed assistance to eat in their rooms before serving meals to people in communal areas. Staff checked people they were enjoying their meal and we observed skilful communication by one staff member, which encouraged the person they were supporting to eat well. Specialised equipment such as plate guards were in use to assist some people to eat independently. We found some improvement was needed to ensure the chef had a comprehensive understanding of how to increase the calorific value (fortification) of food to support people at risk of weight loss. The chef told us they had no formal training in food fortification.

Staff had a good working relationship with the health professionals who visited Brunswick House regularly. One described them as, "attentive, friendly" and "well organised". Another said staff were, "brilliant at communicating with them". They told us referrals to them were timely, staff used the equipment they provided and followed their advice. Staff liaised appropriately with the GP in relation to three people's changing health needs, managed during our inspection. For example, informing the GP of action taken by the rapid response team and working with the GP to meet the person's needs in light of this. This included implementing thickened fluids prior to referral for assessment by a Speech and Language Therapist (SLT). Advice from health professionals, including from hospital appointments, was communicated to staff at handover.

People living at Brunswick House, including those admitted for respite care, were registered with the local GP practice. GP home visits could be arranged when needed to ensure people always had access to appropriate medical care. Each person received an annual health check and medicines review with the GP.

When people had a health care need that required ongoing monitoring, this was carried out by staff in partnership with the GP and relevant healthcare specialists. For example, a staff member told us about the advice staff received from the Specialist Diabetes Nurse, on appropriate management of blood glucose levels for a person they supported. The GP attended the home weekly to review people's changing health needs and saw anyone who was "poorly" more urgently. This enabled people living with dementia to be assessed and treated within an environment that was familiar to them, avoiding unnecessary distress or anxiety which could otherwise impact on their ability to access care.

Staff supported people to attend hospital appointments as needed. People had access to chiropody services and private optical or dental care. Emergency optical and dental care was provided at Brunswick House. People had access to a healthy diet and had access to a suitable exercise programme, provided by a visiting specialist service.

Upper floors were accessible to people via stairs and a small passenger lift, which could hold a wheelchair. People had access to two lounges and a dining area in the conservatory.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and sensitive to their needs. For example, we saw that when a new person arrived at the home, staff welcomed them warmly. Afternoon tea was being served in the lounge and they were asked if they would like to participate. A staff member quietly and sensitively double checked the person's understanding of the situation, informing them there would be a lot of people in the lounge and making sure they were comfortable with this. When people needed help with their personal care, staff made them feel comfortable with this. Comments included, "I have a lovely shower twice a week and feel clean all the time. I need help with all of this. Even when I have an accident in the bed, I feel so embarrassed but they don't seem to mind. They make me feel nice and comfortable again" and "They [staff] are always polite and ask after my welfare."

Staff expressed kindness in the way they spoke about people, for example, a staff member described the person they were supporting as, "my friend", while giving them a quick hug. Another staff member spoke about the "real sadness" staff felt when people they knew well reached the end of their life. They were aware people could become lonely, particularly when they were no longer able to spend time in communal areas and told us how they tried to address this. A staff member told us, staff "Always try and make people's birthday special" and they were particularly aware of those people who had few relatives or visitors on special occasions.

We observed people were relaxed around staff and felt able to ask for assistance. This was reflected in the home's 2017 Residents and Relatives survey, with nine of eleven respondents rating staff attitude and general manner as 'excellent or good', no negative responses were received. External professionals who visited the home regularly said, "I have no concerns at all" and "The carers [staff] all seem lovely. They seem to have a good rapport with their patients."

Some people were able to tell us what they did for themselves and what help they needed from staff. For example, one person was independent with their personal care and administered their own medicines. They preferred that their family did their washing and this was respected. Comments from people and their relatives included, "Nothing is too much trouble. Can't be faulted", "Staff never moan or gripe when asked to pick things up from the floor" and "Staff are very friendly and brilliant." We observed a nurse check a person's blood sugar level. They had a warm rapport with this person, saying "Can I have your finger please madam?" followed by, "That's not bad [person's name] 9.4", to informing the person of the result.

People's activity support plans described what they liked to do and had previously enjoyed. The activities coordinator told us how they worked with a person whose mobility and capacity to understand or express themself was limited, due to advanced illness. They had made a sensory pillow for this person, using different fabrics including leather, rubber and carpet. They said, "When I do a one to one with her, she touches the different materials, there are certain parts she likes to hold. Her daughter was amazed by [person's] facial expression and reaction. It really worked." They spoke with enthusiasm and excitement about 'connecting' with this person, during a weekly singing group visit; telling us, "She really lit up and smiled." Further to this, other staff had used the same approach, sitting with her and holding her hand

during this session.

Resident meetings were held at Brunswick House, where people could express their views. In the home's 2017 annual quality survey, eight of eleven respondents said they were involved in decisions about care and home affairs 'always' or 'most of the time'; two people were unsure.

Staff respected people's privacy and promoted their dignity and independence. Personal care was provided behind closed doors and people were supported to dress appropriately to maintain their dignity. For example, staff responded quickly and kindly, intervening when a person started to remove their clothing in a communal area. While we were observing medicines administration, one person needed an injection. The nurse closed the door and checked if the person minded an inspector being present during the injection. Another person said, "I am able to keep my dignity at all times." We briefly observed a staff member caring for a person after their death; they acted with sensitivity, maintaining dignity and respect throughout.

Requires Improvement

Is the service responsive?

Our findings

Some people had lived at Brunswick House for over a decade and were well known to staff. More recently, an increasing number of people were admitted to the home directly from hospital, for assessment of their needs, or for end of life care. This meant a higher number of admissions to the home and, more people for staff to get to know and an increase in assessments and care plans to be completed.

We found care records lacked sufficient information to enable staff to support people in a person centred way. For example, people's life history, sexuality, interests and beliefs were not consistently recorded or taken into account when planning their care. Support records lacked detail about what people were able to do for themselves and how they liked to be cared for. For example, one person's care plan said, "[Name] should be offered a bath or shower daily. He should be offered help with cleaning his teeth and if necessary shown what to do with the toothbrush. [Name] should be shown his clothes so he can decide what to wear." Details such as whether they wore dentures, how often they cleaned their teeth, shaving habits and how they liked to present themselves were absent. This was significant as some people, including those living with advanced dementia, had limited ability to communicate their wishes and preferences with staff. This meant people's emotional and social needs, in relation to their individuality and sense of self, may not always be recognised and met.

One person receiving regular medicines to prevent constipation had no care plan in place to specify actions needed to maintain their bowel health. A staff member said, "We don't tend to have care plans about constipation." Nurses relied upon care workers to tell them if a person had not had their bowels open and told us this would also be on the staff handover sheet. Clear information was not in place for staff to follow if this person was to become constipated.

End of life care plans were not always in place. We case tracked a person receiving end of life care at the time of our inspection. Information about what was important to them, their interests and religious or spiritual needs had not been recorded and no end of life care plan was in place. Staff were unable to tell us about this person's interests, or give an example of personalised care they had provided to them. When asked specifically about this, a staff member said, "We try to sit with them [dying people] and make sure they're comfortable". When staff were unable to do this, they put the radio or television on for the person to listen to.

People's needs had not been assessed promptly and detailed care plans were not always in place to ensure people would receive individualised care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns about lack of personalisation in care planning, to managers, at the end of the first day of our inspection. When we returned for the second day, managers had begun to address this. Staff had completed 'This is me' documents for 10 people living at the home. These documents were completed with people or by their close relatives, to provide a picture of who the person really is and what matters to them. A manager told us this information would be used going forward, when planning people's care.

Staff worked closely with the GP to ensure people had a dignified and comfortable death. This included clear identification of people for whom a 'do not attempt cardiopulmonary resuscitation' decision had been made. Anticipatory medicines were prescribed and available in the home for people who were identified as frail and reaching the end of their life. These medicines were prescribed by the GP to be given as and when needed to control any pain or discomfort. Some staff had completed specialist training in end of life care and nurses received appropriate updates in the use of specialist equipment, used to deliver some anticipatory medicines.

People's families were encouraged to spend time with them in their last days. We saw relatives were closely involved in decision-making; they were able to visit at any time, including staying overnight if they wished to. Our discussions with the nurse on duty demonstrated how staff responded to relatives concerns and worked with them to ensure the person was comfortable. For example, using careful positioning to minimise symptoms, then using a minimal amount of anticipatory medicines to maintain comfort, when positioning alone was ineffective. Staff demonstrated a caring and respectful approach when caring for a person, who passed away during the inspection. Staff communicated well with the family and allowed them to set the pace.

People's personal routines were respected. People were able to get up when they wanted, to spend time in communal areas or have time alone in their rooms. For example, one person who normally got up early with night staff wanted a lie in that morning, another was up early as they were excited about going out with their relative that day. People were able to ask for what they wanted, for example one rang their call bell for a cup of tea, which was brought to them. No restrictions were placed on visiting and people went out into the community with their families.

People's preference for male or female staff to support them with personal care was respected. One person said, they had requested a, "female for my personal care and when a male staff member came; I reminded them that I had asked for female staff. It was addressed straight away."

Different groups visited the home to give people opportunities to practise their faith, to socialise, exercise and be entertained. A variety of activities and some trips out were arranged, on a group or individualised basis. The activities coordinator had previously studied religion and told us they often got, "lost in deep discussions" with a person (living at the home) who previously worked in this field. One person told us they felt there were not enough activities and we observed opportunities to be limited at times. For example, each person was offered a one to one session with the activities coordinator each month; no additional sessions were available to people who stayed in their room. Relatives were encouraged to visit people at the home and we observed three people going on trips out with their family which they clearly looked forward to and enjoyed.

Technology was used to ensure people received timely support. When people were able to use them, call bells were left within reach so they could seek help. Door and mattress sensors were used when people were unable to use a call bell, but may be at risk of falls, or walking into another person's room, while trying to get where they wanted to be. The provider was in the process of introducing an electronic device for visitors to sign into and out of the house. This was set up during the inspection. The provider's representative told us visitors to the home would also be able to leave feedback about their visit using this device. Leaflets in the home's entrance hall invited people to leave a review of the home on an independent website.

People we spoke with were aware they could make complaints and knew how to do this. The majority of people we spoke with had no complaints about the service they received. However, during our conversations it became evident that people did not always share 'minor' complaints with staff. For

example, people said, "The bed is terrible but I don't like to complain. I don't want to make a fuss; they've got other people to attend to" and "It's just these little things, you feel like you're complaining about nothing, but they are big things to me." Another person told us they had not been given the medicine they requested for indigestion three hours earlier; when it was suggested they should ask again they replied, "No, I don't like to."

Records from residents and relatives meetings showed some people took this opportunity to provide feedback about aspects of the service they received. At a meeting in November 2017, people said they were happy with the food and gave positive feedback about their care staff. We saw these meeting were also used to educate people about healthy living and ways they could enhance their wellbeing. A monthly newsletter was produced and relatives were regularly invited to social events at the home. Some improvement was needed to ensure feedback opportunities were sufficiently effective to ensure people could share all their concerns with the provider.

Two complaints had been logged since our last inspection. One was in progress and the other had been resolved to the complainant's satisfaction. In the latter case, resolution of the complaint resulted in an improved service to the individual in relation to managing their medicines. The resolution involved assisting them to take control of this aspect of their care. To do this, the GP was asked to review their needs, storage facilities were provided in their room and their ability to self-medicate was checked. Staff continued to carry out weekly checks on stock levels and order medicines on their behalf. One other person was also self-medicating in the home and both people spoke positively about the arrangement. Their comments included, "I don't have to rely on somebody coming to help me. I prefer it that way" and "I've got my medication in the drawer by my bed which is locked at all times. I have the key."

Requires Improvement

Is the service well-led?

Our findings

The provider had employed a full-time Quality Auditor, six months prior to our inspection, to carry out comprehensive provider level audits at their homes. An audit had been completed by them at Brunswick House on 24 January 2018. This audit identified some of the concerns we found, for example, in relation to people's care plans. The need to update PEEPS and other shortfalls had also been identified. Other outstanding actions included, for example, all first aid boxes to have contents checked and stocked replenished, some equipment needed to be cleaned and some chemicals and fire extinguishers needed to be stored appropriately. Monthly medicines audits were also carried out.

However, these audits had not been effective in identifying all the shortfalls we found. This included concerns about moving and handling practice, lack of an effective system to assess staff competency, shortfalls in medicines management and that DoLS applications had not always been made when required. Improvements were needed to ensure the provider's audits would be sufficiently comprehensive to identify all potential regulatory and practice concerns.

Prior to the provider's audit on 24 January 2018, the registered manager's own checks had also not identified all these shortfalls in the service. Therefore timely action had not been taken to prevent the quality of the service from falling below an acceptable standard and people had been placed at risk of receiving unsafe care. In audits completed in September and October 2017, the registered manager identified that staff would benefit from training in person centred care planning. However, no actions to address this, such as requesting assistance from the community Care Home Support Team, were evidenced. Despite the registered manager having identified risks in relation to people's care planning three months prior to our inspection, improvements had not been made and people remained at risk of not receiving individualised care.

Complete and meaningful records were not always maintained in the service about people's care. During the inspection we received a concern from commissioners in relation to the standard of documentation at the home. In particular, saying the deterioration in one person's health, including apparent weight loss, was not evidenced in the person's care records. In an entry in another person's record, commissioners requested that staff, 'document when there are resistive behaviours as the care records do not demonstrate any daily incidents/concerns'. These behaviours had been reported to the commissioner by staff, but the lack of records did not allow commissioners to assess the extent of this support need accurately.

Another person had been admitted from hospital, three weeks prior to the inspection. No care plans were in place for this person, despite them being referred for physiotherapy and being investigated for abnormal stools since their arrival. Accurate and complete care records should be kept and be accessible to authorised people, including those from other organisations, in order to deliver people's care and treatment safely, in a way that meets their needs.

Checks were not in place to ensure all equipment was used appropriately and remained safe to use. For example, we found the pressure mattress settings were incorrect for three of the four people we looked at.

There was no system in place to check that mattress settings remained correct for people's weights to protect their pressure areas. The registered manager had not identified that all bed rails were being used safely.

Staff performance monitoring systems had not been operated effectively and the registered manager had not identified that although staff had received training, they did not always have the skills and competency to support people effectively when for example, providing moving and handling support.

Monitoring systems had not identified that the provider's assessment process had not been effectively implemented. People had experienced delays in assessment and review of their needs which placed them at risk of not receiving individualised care.

The above demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Brunswick House Nursing Home had a registered manager who has been in position for a number of years. A registered manager is a person who has registered with the Care Quality Commission 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.

The registered manager told us they planned to "step down" in 2018 and further changes to staffing structure and responsibilities had been proposed by the provider. A Clinical Lead had been in post for four months, which was a new and developing role. These changes had led to some uncertainty and concern, reflected in the mixed feedback we received from staff, relatives and visiting professionals, about staff culture and leadership at the home. A staff member told us the home had been "unsettled" and "not the happiest place" in recent months. We found some staff were less comfortable speaking openly about their experience at the home, while others were highly positive. We saw that staff concerns were being listened to and addressed directly by the management team, though staff and individual meetings. The provider's representative assured us that proposed changes to staffing structure were, "not set in stone."

Support was provided to all staff by the provider's representative, who spoke positively about the home and the contribution staff made. They visited the home twice monthly, usually on consecutive days, which allowed them the opportunity to visit out of hours. Staff told us the provider's representative made a point of speaking with them during their visits and knew what was "going on" at the home. We found the culture was inclusive. For example, a staff member told us how managers supported them to work flexibly, allowing them to practice their chosen religion while still meeting their job specification.

Feedback about the service was sought through several routes, for example, in surveys and resident meetings and this was acted upon. Open events at the home promoted the engagement and involvement of people, the public and staff. The provider ensured the quality of the service was discussed with staff and staff felt they were able to suggest ideas about the day to day running of the home. Staff meetings were used to discuss key points such as medicine management, CQC inspections and training. This ensured the registered manager was able to discuss key information with staff at the home. Records showed these staff meetings had not always taken place regularly and the registered manager told us they were taking action to ensure for example night staff meetings took place regularly.

The registered manager worked with other organisations to source appropriate training and updates, including local hospices and other NHS services. They attended Registered Managers Network meetings to

update themselves about relevant national and local changes.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not always assessed promptly and detailed care plans were not always in place to ensure people would receive appropriate care that met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided safety as all practicable steps were not taken to mitigate risks to people and people's medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority or application to the authorising authority having been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not sufficiently robust or operated effectively to monitor and improve the safety of the services provided.

Accurate and complete records of the care and treatment provided to people had not always been kept.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Appropriate training and supervision had not always been provided to staff to ensure they had the skills and competency to carry out their duties suitably.