Buckland Care Limited

Brunswick House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Brunswick House is a residential care home providing personal and nursing care to a maximum of 46 people. The service provides support to older people, some of whom live with dementia. At the time of our inspection there were 41 people using the service. People are accommodated in one adapted building which has been extended.

People's experience of using this service and what we found
We found the improvements required following our last inspection had been made. The provider had effective quality monitoring processes in place and the management of people's care records had improved.

Prior to our inspection the registered manager had left and the deputy manager was now the new manager. They had been in this role for 6 weeks. They had been involved in the improvement program so were well informed about what now needed to be sustained.

People were aware of the change in management but were not concerned by it. They told us they already knew the new home manager, who they described as "friendly" and "approachable". Staff felt supported and valued by the senior staff and were working with them, as one team, to provide people with the services they required. The new home manager had a clear vision for the service and had the support of the provider's representative to achieve this.

People told us they felt safe because the staff were caring, friendly and always available to help them when needed. We found, there were enough staff to meet people's care needs and to respond to them when needed to ensure their safety. People's medicines were managed safely. People told us the home was kept clean and we found effective cleaning and infection, prevention and control arrangements in place. Safety checks and servicing arrangements ensured the ongoing safety and effectiveness of the building, equipment, all utilities and emergency systems.

People told us their health needs were met and they had access to the health professionals when needed. We spoke with two health care professionals who confirmed staff worked well with them to support and maintain people's health. People's care records provided clear information about their needs and how these should be supported. Staff were provided with training and support to meet these needs effectively. People told us their consent was sought and they were able to make independent decisions about their care and treatment. People's nutritional needs were assessed and met. People told us staff were aware of and met their personal choices and cultural preferences regarding food and drink. Changes were made to people's environment, their equipment and the care delivered to them as their needs altered.

People were supported to have maximum 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.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 3 November 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
This inspection was planned to see if the provider had met their action plan regarding the actions, they told us they would take to improve. We had also received concerns in relation to staff availability, staff culture and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We found no evidence during this inspection that people were at risk of harm from these concerns.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection these were inspected, to calculate the overall rating. The overall rating for the service has changed from requires improvement to good based on the findings of this inspection.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below

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 Health and Social Care Act 2008.

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
One inspector and 2 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 and/or personal care as a single package under one contractual agreement dependent on their registration with us. Brunswick House] is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The newly appointed home manager was completing their application to us to become the service's registered manager.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
On-site we spoke with 10 people who used the service and 2 relatives to gain their view of the services provided. We spoke with 9 staff which included; the manager, deputy manager, a nurse, a team leader, the housekeeping and services manager, head cook, maintenance person and a housekeeper. We spoke with the provider's representative, the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 2 visiting health professionals, one of whom visits the care home regularly. 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. Off-site we spoke with a further 9 relatives (by telephone) to gain their view of the services provided.

We reviewed 6 people's care records including a selection of medicine records and records related to the Mental Capacity Act. We reviewed 3 staffs' recruitment records, the staff supervision program and service's training record. We reviewed cleaning records. We also reviewed records related to the management of the service, which included, audits.

Good

Is the service safe?

Our findings

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

At our last inspection this key question was inspected but not rated as we did not look at all aspects of the key question. At this inspection this key question was fully inspected and rated good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Processes were in place to protect people from abuse. Staff knew how to identify and appropriately report any concerns. Managers ensured relevant information was shared with the local authority, police and us (CQC) so measures could be taken to safeguard people.
- People and their relatives told us they felt able to talk with either the manager or deputy manager about anything which may concern them.

Assessing risk, safety monitoring and management

- Risks to people were assessed and managed to mitigate or reduce harm to people. The actions taken to reduce risks were reviewed to ensure they remained effective in mitigating and reducing risks to people, visitors and staff. This included environmental risks such as those posed by fire, infection, provision of unsafe water, poor food hygiene, falls from a height and equipment failures.
- Records showed regular safety checks and servicing arrangements were in place and completed, as part of the provider's overall health and safety program.
- All staff received training which enabled them, in their individual roles, to understand their responsibilities and to maintain safe ways of working.
- People's individual health and safety risks, were also assessed, managed and action taken to mitigate or reduce these. Falls prevention included actions to try to prevent further harm to people. A relative told us, "Initially [name of person] was in an upstairs room and after a while they started to have a few falls, so it was decided to move them downstairs so that a closer eye could be kept on them, so yes, I think that was a good action to take to keep [person] safe."

Staffing and recruitment

- Records showed safe recruitment of staff took place. Checks were completed through the Disclosure and Barring Service (DBS). These checks provide information including details about convictions and cautions held on the Police National Computer. Gaps in employment and reasons for leaving previous jobs explored and references were requested prior to employment. This information helps employers make safer recruitment decisions.
- There were enough care staff and nurses employed to meet people's care and health needs. Where needed agency staff were used as support, but successful recruitment had helped to reduce the need for this.
- The provider had been creative and had developed the role of care support assistant and had been successful in recruiting these staff. These staff provided additional support to people when care staff and nurses were busy. They ensured people were supported to access the toilet, were provided with drinks,

snacks, reassurance and supervision as needed.
● A new activities co-ordinator had just been recruited to replace the one which had just left. It was hoped a second activity support member of staff would also start soon.

Using medicines safely
● There were arrangements in place to ensure people's medicines were ordered, delivered and made available for when they were needed. This included 'just in case' medicines for end of life. All medicines were stored safely. A person told us, "They [staff] bring the tablets down each day, stay and make sure I have taken them."
● A visiting health professional told us people's medicines were reviewed on a regular basis and staff were good at appropriately flagging up any concerns relating to people's medicines. Staff were aware of potential complications from the use of some medicines which treated dementia, risk of blood clots, anxiety and distress. They observed for increased sleepiness, falls, confusion and bruising and these were reported and discussed in that review.
● Additional monitoring of some people's medicines was required when their needs were more complex or changeable. This included people who lived with conditions such as Multiple Sclerosis, Parkinson's Disease diabetes and epilepsy.
● When people required their medicines to be administered covertly (hidden in food or drink) staff took advice from a pharmacist on how the medicine should be added to food or drink to maintain its effectiveness.

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 supporting people living at the service to minimise the spread of infection.
● 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 were assured that the provider was responding effectively to risks and signs of infection.
● 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 have signposted the provider to resources to develop their approach.

● There were no restrictions to visiting, people could receive visitors when they wished to.

Learning lessons when things go wrong
● Learning had been taken when potential risks to people were identified and staff required guidance, which was in line with nationally recognised best practice guidance, on how to manage these risks. This had resulted in managers amending the prompts, used by staff when they developed electronic care plans, so best practice guidance was incorporated. We saw this take place in relation to care plans for the management of seizures.

Good

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

At our last inspection the provider had failed to maintain accurate records about people's care. This placed people at risk of not always receiving their care in accordance with their assessed needs. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- People's care records had improved, and they now provided a more accurate and detailed record of the care delivered, which was in accordance with people's care plans.
- Action had also been taken to improve the content of people's care plans. These provided staff with clear guidance on how people's needs should be met.
- Managers could alter the prompts, used by staff when developing an electronic care plan, to ensure the care plan incorporated best practice guidance. We saw this completed for seizure and urinary catheter care planning. One person's diabetes care plan was also personalised to their needs and had been developed with the support of a diabetes nurse specialist.
- People's care and health needs were assessed using recognised assessment tools. This included needs associated with risks such as falls, choking, malnutrition, pressure ulcer development, moving and handling including behaviours arising from anxiety and distress.
- Care plans incorporated people's choices and preferences; including cultural preferences and end of life wishes. A person told us, "I Know they did ask me lots of things, came to see me. What food I liked, what sort of care did I want that sort of thing".

Staff support: induction, training, skills and experience
- All staff completed induction training when they first started work for the provider which included an introduction to the provider's policies and procedures.
- The staff training record showed staff were up to date with trainings the provider considered to be mandatory for all. This included subjects such as safeguarding, fire safety, infection control and COVID-19, equality, diversity and inclusion, dementia, the Mental Capacity Act, nutrition and hydration and identifying sepsis. A member of staff told us, "We do a lot of training."
- Staff were provided with training and support to further develop their knowledge and skills according to their role, responsibilities and interests. One member of staff had completed further study on tissue viability

and wound care and was the team lead on this subject. They liaised with an NHS specialist tissue viability nurse and worked closely with them to ensure people received effective wound care.

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

● People were provided with support to eat and drink. We observed care staff, but also care support assistants and housekeeping staff, continually ensuring people could reach their drinks and had replenished drinks. We observed care staff assisting people to eat in a dignified and unrushed way. When talking with relatives about the support provided at mealtimes, a relative told us, "[Name of person] is even putting on weight, and yes [person] really does enjoy the food."

● At mealtimes we observed people being supported to make food choices. A person told us their food was provided in accordance with their religious preference. Another person told us, "I like the meals, tasty and the sort of things I like to eat. Good chef, if I don't like anything will do me different stuff, sandwich, or an omelette, obliging."

● People's eating and drinking needs were assessed. People with swallowing difficulties or who were at risk of choking were provided with textured altered foods. These were prepared in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI) standards and instruction provided by speech and language therapists.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff worked with a range of health care professionals to ensure people's needs were met. This included specialists in diabetes, Parkinson's Disease, mental health and stroke rehabilitation.

● People were reviewed weekly by either the attending GP or the advanced nurse practitioner attached to the GP practice. This meant people's medical needs were routinely reviewed and referrals to specialist health care professionals were made where required.

● Staff were able to access support from NHS Rapid Response teams when people's health declined. People were assessed by a clinician and, where safe do to so, received medical support in the care home. This had often helped to avoid admission to hospital.

● People had access to services which supported an ongoing healthier life, such as NHS dental and optical services. A Chiropodist also visited providing regular footcare and helping to maintain people's mobility. A person told us, "I have had the nurse from the surgery round and can see a doctor if I need to. I am having my eyes checked, the optician comes here."

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

● The environment of the care home was adapted to help meet people's physical, psychological and social needs.

● The design and decoration of the main lounge had been altered and improved. People had been involved in choosing the colour scheme and decoration. A feature fire had been installed one end of the room to help develop a more domestic style and comfortable area for people to sit in. A person confirmed they enjoyed sitting in this area.

● A table and chairs placed alongside a full-length window, looking out onto the courtyard garden, offered an alternative place for people to sit. Placed in an area wide enough to accommodate wheelchairs, we observed people sitting there, reading, chatting and enjoying the sun.

● Adaptions were in place to prevent accidents and to support people's access to communal facilities such as bathrooms. Specifically, designed railing and stair gates were in place on the upper floors preventing access to the stairs by people who may fall. External doors were adapted to avoid people who would not be safe leaving the home unescorted, from exiting the building.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People were supported to make independent decisions about their care and treatment. Where people had not been able to make independent decisions, we saw mental capacity assessments had been completed, in relation to the decision needing to be made, and where required, a decision had been made in the person's best interests.
● DoLS were applied for when people could not consent to live at Brunswick House. In one person's case this had been done because, although the person was consenting to stay, they could not mentally retain the reasons why they needed care home support.
● There were no conditions applied to the current DoLS which had been authorised.

Good

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

At our last inspection the provider had failed to operate effective monitoring systems to ensure quality and safety processes were sufficiently and effectively implemented and operated. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● The manager had a good understanding of their regulatory responsibilities. They were being inducted into the provider's management processes by the provider's representative. The manager was in the process of applying to CQC to be the registered manager of the service.
● The manager was familiar with many of the quality monitoring audits which needed to be completed as part of the provider's annual audit plan. We reviewed a selection of completed audits which were in the process of being reviewed by the provider's representative.
● Actions from these audits were transferred to the service improvement plan (SIP). The provider's representative could access this at any time to monitor the service's progress in completing these actions. On a monthly basis, the SIP was formally reviewed with the manager and the provider representative signed off completed actions on behalf of the provider.
● Since our last inspection the provider had made improvements to how their senior management team monitored their service's. This included a formal monthly audit, of all electronically held information, including care records. This along with additional monitoring information gave the provider better oversight of all their services. It enabled them to identify patterns, trends and areas for improvement, across all their services. This supported stronger and more effective provider governance arrangements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager promoted a friendly, open and inclusive environment both for people who used the service and for the staff who worked there. People told us the manager and deputy manager were "approachable" and "friendly". A person told us, "I see the manager around, she is nice and approachable, and the deputy is nice to. You can talk to them if you want to." A member of staff told us, "I can ask [name of manager] the

silliest of questions and she helps me."
● The manager told us the people who lived at Brunswick House came first and the priority was for them to remain safe and to receive personalised care. The manager monitored the staff culture and had made some adjustments to ensure this remained positive and people focused. A member of staff tolds us, "[Name of manager] is firm but fair, doesn't put up with any messing. I like that."
● Staff were supported to contribute and share their diverse qualities in order to strengthen the team. We observed a strong team ethic where the overall staff team worked together to achieve good outcomes for people. An employee of the month scheme recognised individual positive contributions.

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 manager and provider's representative understood their legal responsibilities regarding duty of candour. During the inspection we discussed how they had managed situations which had required them to be open and honest with people or their representatives.
● Learning was taken from any concerns or complaints raised and where needed; reflective processes used to support this. Any concerns or complaints received were monitored by the provider's representative to ensure these were responded to in accordance with the provider's complaints policy.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A plan was in place for face to face relative meetings to start again following the pandemic. A relatives meeting was due to take place later in the month. Relatives told us they had felt well communicated with by telephone and email and were able to give feedback when needed. There was also a regular newsletter provided to relatives and people who used the service. Information could be provided in different languages and large print.
● People confirmed they either had regular contact with the manager and deputy manager or they knew who they were, because they are visible, and they could speak with them if they chose to. When asked if people felt the home was well managed a person told us, "I think that it is alright and as far as I know well managed because things run along smoothly."
● Regular staff meetings were planned throughout the year and a night staff meeting was due just after the inspection. The manager met collectively with heads of department, daily, to review each departments progress, challenges and to discuss and monitor known and newly emerging risks.
● Staff handovers took place daily when staff were updated with any changes to people's or any other news, they needed to be aware of.

Working in partnership with others
● The manager was keen to re-build community contacts following the pandemic and a good support network was in place with the local church.
● The manager and senior staff team worked closely with commissioners of care so people could access the support the service could provide, when they needed it.