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Brunel House

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
Brunel House is a care home providing nursing and personal care to 40 people aged 65 and over at the time of the inspection. The service can support up to 65 people. People live on three floors of the building, one of which specialises in providing care to people living with dementia.

People's experience of using this service and what we found
The provider did not always ensure there were enough staff working in the home to meet people's assessed needs. People, their relatives, staff and visiting professionals told us there were not enough staff working in the home at times. The lack of staff impacted on people's ability to receive care in a timely way. Staff felt they were rushing when providing care for people and were not able to provide person-centred care.

Risks to people were not always effectively assessed and managed. Action was not consistently taken following incidents to reduce the risk of a similar incident happening again.

The provider did not have effective systems in place to assess the quality of the service provided and make improvements where needed. The management team had not completed some of the regular checks and audits that were needed for effective oversight of the service. The systems had not identified some of the shortfalls we found during the inspection.

We made a recommendation that the provider reviews the medicines management practice, to ensure their procedures are followed consistently. There was not always an accurate record of medicines held in the service and one person regularly received time-specific medicine either early or late.

The home had good infection prevention and control procedures in place. Procedures had been reviewed and updated to reflect the COVID-19 pandemic. Systems were in place to prevent visitors catching and spreading infections.

The regional director had identified the need for improvement in the service and had brought in a 'service support team'. These were additional staff tasked with identifying and implementing improvements to the service.

Staff demonstrated a good understanding of people's individual needs and a commitment to provide person-centred care. However, they were frustrated at the staffing circumstances which made this difficult.

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 10 January 2020) and there was a breach of regulations. The provider completed an action plan after the last comprehensive inspection to

show what they would do and by when to improve. We completed a targeted inspection in February 2021 and the provider had made the improvements necessary. At this inspection we found the service had deteriorated and there were further breaches of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing and management of the service. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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.

Brunel House

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of two inspectors 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.

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

The service did not have a manager registered with the Care Quality Commission. It is a condition of the provider's registration that there must be a registered manager for this service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service and the service provider. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We received feedback from two professionals who have contact with the service. We used all of this information to plan

our inspection.

During the inspection
We spoke with two people and one relative to gather their views about the care they received.
We looked at 12 people's care records. We checked recruitment, training and supervision records for staff and looked at a range of records about how the service was managed. We also spoke with the manager, human resources manager, regional director and six care and nursing staff. 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke to nine relatives and four staff by phone.

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 requires improvement. At this inspection this key question has remained the same. 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
At the last comprehensive inspection in January 2020 we recommended the provider reviewed how staffing levels were determined. At this inspection we found the arrangements for staffing the service had deteriorated.

- The provider had failed to ensure sufficient staff were deployed to meet people's needs. People, relatives and staff consistently told us there were not enough staff available. Comments included, "I don't get as many baths now" and "There are not enough carers or cleaners." Comments from relatives included, "The staff seem stretched and stressed especially when someone has called in sick."
- All of the 10 care staff we spoke with expressed concern about staffing levels and their ability to provide care for people. Comments included, "Staff need to help people quickly and not as well as they would like, to get to everyone. If they spend more time with a person doing it properly, they don't get around everyone" and "You can't provide the care to residents."
- Staff told us the home had been left without a nurse on duty the day before the inspection. The manager said they had been the nurse on duty for the home as the scheduled nurse was absent due to sickness. The manager confirmed they had left early, leaving the home without a nurse, and that this was an "oversight" on their part. The manager said when they left, they had forgotten the nurse who should have been on duty was absent.
- Health and social care professionals who have contact with the service raised concerns with us about staffing levels in the home. A GP raised concerns that a nurse covering a night shift did not have the right skills and competencies to manage a syringe driver for a person. A social worker reported that the manager did not recognise the impact staffing issues were having on people.
- The manager said staffing was their biggest issue, due to many care and housekeeping staff that had recently left the service. Staff rotas did not give clear information about how many staff had worked on specific days. On discussion with the manager about staffing levels, they were not able to demonstrate they had deployed sufficient staff to meet people's assessed needs over the previous month.

The provider had failed to ensure there were sufficient staff deployed at all times to meet people's assessed needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- New staff were thoroughly checked before they started working. The provider had completed a criminal record check and obtained references from previous employers of new staff before they started supporting people. Staff records contained all necessary information, including a full employment history and confirmation of their right to work in the UK.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

● The risk of harm to people was not always effectively assessed, managed or reviewed following incidents. There were not consistent systems in place to identify when things had gone wrong and learn lessons from incidents.

● Incident records had not always been completed fully or reviewed by the manager to ensure measures were put in place to prevent a repeat of the incident. Examples included a lack of observations of people following falls to monitor for signs of injury and a lack of action to manage the risks of physical altercations between people.

● Staff had not always identified allegations of abuse or taken action to safeguarding people. The record of care for one person contained details of an allegation that they had been hit by a member of staff. This had not been reported to the management team or to the local authority safeguarding team. The management team had not reviewed the records or identified the allegation. We reported our concern to the manager and regional director, who said they would take action to report the allegation.

● On the first day of the inspection one person had a 'child gate' across their door to prevent other people entering their room. No assessment had been completed of the risks to people injuring themselves falling over this gate, or plans put in place to mitigate those risks. The manager developed risk management plans for this after we told her of the shortfall.

● Systems to ensure the building was safe were not always implemented. Monthly safety checks on fire doors, profiling beds, wheelchairs and extractor fans had not been completed as necessary. The manager reported this was due to absence of maintenance staff.

We found no evidence that people had been harmed however, the provider had failed to consistently identify and assess risks so that action could be taken to keep people safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines records were not always maintained accurately. Medicines for two people had been received into the service but not recorded. This meant the record of medicines held did not match the actual stock of medicines.

● Most people were supported to take their medicines on time. However, one person had not received their time-specific medicines on time. Records demonstrated the person consistently received their medicines up to an hour early or late.

● Medicines administration records had been completed for tablets and liquid medicines people were prescribed. These gave details of the medicines people had been supported to take. However, the records for people prescribed emollient creams were inconsistent, with a lot of days when there was no record of people being supported to use the cream.

● Where people were prescribed 'as required' medicines, there were clear protocols in place. These stated the circumstances in which the person should be supported to take the medicine.

We recommend the provider reviews the medicine management practices to ensure their procedures are followed consistently.

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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● 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.

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 comprehensive inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The management team did not have clear oversight of the service and were not meeting the provider's expectations on governance systems.
- Oversight meetings and communication between different departments were not taking place consistently. Records demonstrated the daily heads of department meetings had only taken place four times in the first 20 days of October. Clinical governance meetings, which should be held weekly, had not taken place at all in August and September 2021.
- The oversight systems had not identified staff had recorded an allegation of abuse in the daily care records but not acted on it to ensure the person was safe.
- Monthly audits of key records in the home had not been completed in September 2021. These included checks of care plans, medicines, infection control systems, nutrition and health and safety.
- The service did not have a registered manager. The manager had been in post for approximately three months and said they were planning to apply to register with CQC. The provider is required to have a registered manager at the service as a condition of their registration.

The provider had failed to have effective systems to assess, monitor and improve the quality of the service provided. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The regional director reported they had identified the need for improvement and had brought in a 'service support team'. These were additional staff tasked with identifying and implementing improvements to the service. The regional director had also developed a home improvement plan. Shortfalls identified during the inspection had been added to the plan where necessary.

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

- The management of the service had not supported staff to work in a person-centred way. The high staff vacancy rate had resulted in high levels of temporary staff use who did not have knowledge of people's needs. Comments from people included, "The agency staff are ok, but we have to tell them what to do as they don't know us" and "If I ask for a bath it depends on what staff are around, as there are lots of agency

staff."
● Staff demonstrated a good understanding of people's individual needs and a commitment to provide person-centred care. However, they were frustrated at the staffing circumstances which made this difficult.
● The regional director had a good understanding of their responsibilities under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The service had held meetings for people and their relatives to provide feedback about the service. This feedback was used by the provider to develop the home improvement plan.
● Most of the relatives we spoke with were happy with the way the service had involved them and kept in contact with them.
● The provider had held meetings with their human resources team in response to a high number of concerns raised by staff. Feedback from staff was mixed regarding whether this had resulted in any improvements. Most concerns related to staffing levels and the approach of the manager.
● A health and social care professional who provided feedback to us said the manager did not recognise concerns raised by professionals and families or take effective action to address them.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to consistently identify and assess risks so that action could be taken to keep people safe. This placed people at risk of harm. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have effective systems to assess, monitor and improve the quality of the service provided. Regulation 17 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient staff deployed at all times to meet people's assessed needs. Regulation 18 (1).