Care Quality Commission

Care UK Community Partnerships Ltd

The Burroughs

Inspection report

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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**

Overall summary

The inspection took place on 22 September 2015 and was unannounced.

The last inspection of the service was on 29 April 2014 where we found no breaches of Regulation.

The Burroughs is a residential home providing personal care for up to 75 older people. Some people were living with dementia. The home is managed by Care UK, a national organisation. At the time of our inspection 67 people were living at the home. There was a registered manager in post. 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 and associated Regulations about how the service is run.

The staff did not always follow the directions of healthcare professionals with regards to the consistency of the food people were given, therefore people were at risk of choking.

People had not always been involved with or consented to their care plans.

Summary of findings

We identified some risks to people's health, safety and well-being. The provider had taken action to reduce these risks but the action had not been sufficient to mitigate against the risk of harm.

The staff had completed risk assessments which were accurate, up to date and included plans to manage the risks to people.

People's medicines were managed in a safe way.

The staff had the training and support they needed to care for people.

People's nutritional needs were met.

People's health care needs were met.

The staff were kind, polite and caring. People had good relationships with the staff.

People's privacy and dignity were respected.

People's care needs had been assessed and planned for. People received care which met their individual needs.

There was a range of organised activities, although some people told us they were not aware of these and some people told us they felt lonely.

There was an appropriate complaints procedure and people felt able to make complaints or raise concerns.

The provider had comprehensive systems for auditing the home and asking stakeholders for their feedback and opinions.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

The staff did not always follow the directions of healthcare professionals with regards to the consistency of the food people were given, therefore people were at risk of choking.

There were not always enough staff on duty to meet the needs of people who lived at the home.

The staff had completed risk assessments which were accurate, up to date and included plans to manage the risks to people.

People's medicines were managed in a safe way.

Is the service effective?

Requires improvement

The service was not always effective.

People had not always been involved with or consented to their care plans.

The staff had the training and support they needed to care for people.

People's nutritional needs were met.

People's health care needs were met.

Is the service caring?

Good

The service was caring.

The staff were kind, polite and caring. People had good relationships with the staff.

People's privacy and dignity were respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care needs had been assessed and planned for. People received care which met their individual needs.

There were a range of organised activities, although some people told us they were not aware of these and some people told us they felt lonely.

There was an appropriate complaints procedure and the people felt able to make complaints or raise concerns.

Is the service well-led?

Requires improvement

The service was not always well-led.

Summary of findings

We identified some risks to people's health, safety and well-being. The provider had taken action to reduce these risks but the action had not been sufficient to mitigate against the risk of harm.

The provider had comprehensive systems for auditing the home and asking stakeholders for their feedback and opinions.

The Burroughs

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 checked 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 took place on 22 September 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor and an expert-by-experience. The specialist advisor was a dietitian and she looked at whether people's nutritional needs were being met. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had personal experience of caring for someone with dementia.

Before the inspection we looked at all the information we had about the provider, including the last inspection report, notifications of significant events and safeguarding alerts.

During the inspection we spoke with the staff on duty, including care staff, team leaders, activity coordinators, the catering staff, laundry and cleaning staff, maintenance workers, the registered manager and the deputy manager. We spoke with 20 people who used the service and eight visitors. We observed how people were being cared for and supported. We looked at the environment.

We looked at the care records for eight people, the staff recruitment records for five members of staff, records of staff training, supervision and meetings, records of complaints and the provider's own checks and audits of the service. We also looked at the most recent quality monitoring report from the London Borough of Hillingdon.

Requires improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe at the home. Some people told us they were concerned because personal belongings had been taken from their bedrooms and not been found or replaced. People told us that call bells were answered promptly. People told us they were worried there were not always enough staff on duty and one person said, ''you have to ask for everything you want.''

The care plan for one person contained two assessments from the Speech and Language Therapist (SALT) written in August and September 2015. The assessments stated the person should be given pureed food and thickened fluid. The information included the specific categories of texture the person required to prevent the risk of choking. During our inspection we saw this person was offered toast by two different members of staff and was given a digestive biscuit by a third member of staff. The person was also given a drink which had not been thickened. The staff member was not aware of how much of the prescribed thickener was needed to make the correct consistency for this person's drink. The lunch time meal served to this person was soft but was not the exact texture specified in the person's assessment. The catering staff did not have clear guidance about the different categories of texture and were unable to tell us how about these. Therefore the person was at risk of choking because they were not always given the consistency of food and drink which reflected their assessed needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager contacted us following the inspection to tell us that training had been arranged for the catering staff regarding the texture and consistency of food. The manager had also shared information on the different categories of food consistency with the staff. All staff had been reminded of the importance of following guidance on special diets and where people were at risk of choking. She said that the information in the person's care plan had been updated and that she had requested a further assessment and information from the SALT.

The care staff and team leaders told us that they were short of staff on the day of our visit due to sickness and short notice absence. The manager told us that replacement staff had been brought in to cover the absences by 11.30am. The staff said that staff shortages regularly happened and that it had an impact on meeting people's needs. For example, one member of staff told us that they did not have time to read people's care plans and this meant they were not always aware of their needs. They told us about an incident when they had almost given someone a food they were allergic to because they had not read the person's care plan and did not know. Other staff confirmed that they did not have time to read people's care plans and said that they did not always know about people's needs. The staff who had offered toast to the person on a pureed diet told us they did not know about the person's dietary needs.

Breakfast on the day of our inspection was served late for some people who did not receive this until 10.30am. One person told us they regularly did not have breakfast until 10.15am and that they were ''very hungry by then''. The staff supporting people at breakfast appeared rushed and did not always meet people's needs. For example, we heard one person calling out, ''I am hungry.'' The person asked two different members of staff for toast, however, neither member of staff brought this to them. When we asked the staff about this they told us that they had been busy and had forgotten. We observed one person struggling to eat their cereal and using their hands rather than a spoon to do this. The staff did not notice this for some time as they were attending to other tasks. One person told us that they were not always offered a choice of meals because there was not enough staff to do this. People living in one part of the home were not served their lunch until 40 minutes after they were seated in the dining room. They told us this was because there were no staff available to serve the meal.

On the day of our inspection the majority of people on the ground floor were seated in one lounge for the morning. The staff on duty told us that, although people had a choice to spend time elsewhere, it was easier for them to know where everyone was when they were short staffed. We saw some people getting out of their seats to leave the lounge and being guided back to the lounge by the staff. The staff on duty told us that two people were still in bed at 11am and this was not their choice, it was because they had not had time to help them get up. The staff said that they supported people to wash and get out of bed according to the staffing levels rather than people's choice, therefore if they were short staffed they left people who required two members of staff until last.

Requires improvement

Is the service safe?

Some people on the first floor told us they were lonely and the staff did not always have time to talk to them. They said that if they stayed in their rooms then the staff did not spend any time with them. Some of the relatives we spoke with were concerned that their relatives were not offered regular baths or showers. The staff told us they tried to give people regular baths and showers but this depended on the number of staff on duty.

Therefore the deployment of staff meant that people's needs were not always being met and sometimes they were at risk because of this.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us there was a problem with high sickness levels and short notice staff absence at the home. She said that the home was fully staffed and they had a team of bank (temporary) staff and used agency staff who were familiar with the home to provide cover, however it was not always possible to cover short notice absences. The Manager also told us they were following the provider's policies and procedures to support individual members of staff who regularly did not attend work with little or no notice. The manager recognised the concerns raised by staff that they did not have time to read care plans, and she had introduced one page profiles which outlined people's needs and any allergies or specific requirements. We saw some examples of these. The staff told us they had verbal handovers twice a day but not for changes of staff in the afternoon. They said these were useful for updating each other on information about people using the service.

The provider had a policy and procedure for safeguarding adults. The staff had all received training in this. They were able to tell us about the procedure and what they would do if they suspected people were being abused. They were able to tell us about different types of abuse. We saw that there were posters and information for staff about safeguarding vulnerable people. The staff told us their training was updated annually and we saw evidence of this.

The provider kept records of safeguarding alerts and how these had been responded to. At the end of 2014 the provider received a complaint which included an allegation of abuse. This was not recognised and the provider did not notify the local safeguarding authority, which they should have done. The allegation was reported and investigated at a later date and the provider developed an action plan which included recognising and acting on allegations as soon as they were received. Since this time the provider has notified the Care Quality Commission and local safeguarding authority of allegations and has taken appropriate action to work with others to investigate and act on these concerns.

The risks that people were exposed to had been assessed. These included risks of moving safely around the home and risks associated with their mental health needs and dementia. The staff had recorded these assessments and the action they needed to take in order to keep people safe. Assessments had been regularly reviewed.

The provider made checks on the safety of the environment, including equipment, water, gas and electricity. These were all up to date and action had been taken when problems were identified. The provider employed full time maintenance workers who attended to any repairs and environmental risks. There was an up to date fire risk assessment and the staff had received training in fire safety. Each care plan included information about the level of support people required if evacuating in even of a fire. Bedroom doors were also coded to show the level of support the occupant required to evacuate. There were procedures for dealing with different emergencies and different senior managers were on call at all times.

People told us they were happy with the support they received with their medicines. There was a procedure for managing people's medicines. The staff responsible for administration of medicines had received training in this. Medicines were stored securely. Records of administration were up to date and accurate. There was information about the different medicines people were administered but there was not always clear guidance when people were prescribed as required (PRN) medicines. For example one person had been prescribed eye drops to ''use as required.'' However, there was no additional guidance for staff about when or how to administer these and therefore the staff may not be able to make the correct judgement about whether the medicine was needed or not. The provider carried out audits of medicine storage and records. These were up to date, identified any concerns and recorded the action taken to remedy these.

Requires improvement

Is the service safe?

The environment was clean throughout and there were posters about water temperatures in the bathrooms. Bathrooms and toilets were equipped with soap, hand sanitiser and paper towels.

Requires improvement

Is the service effective?

Our findings

People told us they had not been involved with planning their care and did not know if they had a care plan. Some of the families told us they had not been involved in care planning. There was no record of people's consent to their care plans. The Care Quality Commission oversees how providers are meeting the Mental Capacity Act 2005. It is a legal requirement that providers obtain people's consent to care and treatment.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014

The team leaders told us that they met with the person and their representatives to assess their needs and that care plans were based on these assessments. The staff asked for people's consent before they offered them any care or support.

People living at the home and their visitors told us they thought the staff were well trained and skilled.

We spoke with a number of staff who had been recently employed at the service. They told us they had received a comprehensive induction. They said that they had shadowed experienced staff and had received training at the service. They said that they had felt supported by the team and well informed about their role and responsibilities. The provider organised a range of training courses which staff were required to attend. In addition one of the team leaders at the home was a qualified trainer. She told us that she trained and assessed people's competency for infection control and safely moving people. The trainer was aware of the new requirements for training care staff and the provider had organised for all new staff to undertake this. Their work and learning was assessed before they were considered competent to carry out key tasks of their role. The provider's records of staff training showed that staff received regular training updates. The staff were able to tell us about the training they had undertaken and how this had benefited them.

The staff told us they felt supported and worked well as a team. They said that there was good communication between the team. The staff had regular group and individual meetings with their line managers. They spoke positively about the support of the team leaders. We saw team leaders supporting people, leading by example and guiding staff in areas of good practice. There was evidence of regular meetings. The staff told us that if they had any concerns or wanted to discuss any aspect of their work they could do this whenever they needed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The manager demonstrated a good understanding of their responsibilities in respect of this. They had liaised with the local authority and had made applications where restrictions applied, for example for people who were unable to safely leave the home without an escort. There was a record of DoLS applications and authorisations. People's care plans were updated with this information. The staff had received training in the Mental Capacity Act 2005. They had a good understanding of this and their responsibilities.

There were no bed rails or other physical restrictions for people, with the exception of a secure lap belt for one person's wheelchair. Decisions about the use of this had been recorded. The provider had made an application under DoLS in respect of this. Some of the doors to different areas of the home were secured with keypads. Where people were unable to leave because they could not use these without support the provider had made an application under DoLS. The manager told us there were six people who had a Do Not Attempt Resuscitation order in place. She told us the staff were liaising with the families of these people and their GP to make sure these were in the person's best interest where they lacked capacity to make the decision themselves. The manager told us about some people who did not have the capacity to consent to certain decisions. They told us that best interest meetings involving the person's next of kin and other professionals had been organised to decide what action to take in people's best interests.

People's capacity to consent had been assessed and recorded, including the level of their capacity to make different decisions.

The home was a large purpose built two storey building. There was a large courtyard and garden which the staff told us people enjoyed the use of. There were a number of different communal areas including a coffee shop, cinema

Requires improvement

Is the service effective?

room and sensory room. There were some features designed to offer people an interactive environment, including different textures and wall mounted games. The activities officers told us they had researched how to enhance environments for people with dementia and had started to improve the environment with the use of appropriate furniture, décor and colours. There were some attractive features and the environment was welcoming, light and airy. However, there was not always useful signage or features to help orientate people around the environment and some people told us it was confusing to find their way around. One visitor told us there were not always wheelchairs available so they could take their relative in the garden and on the day of the inspection they said that the only available wheelchair was broken. The manager told us there were ten wheelchairs available at the home for people to use and six of these had been recently purchased.

People's nutritional needs were assessed when they moved to the home and regularly updated. We found that the staff had not always completed the assessments accurately so that information about people's weight loss was not always correctly recorded. However, the staff had identified when people had a nutritional need and appropriate referrals had been made to dietitians and other professionals where needed. The staff weighed people regularly but people at high risk of malnutrition had not always been weighed weekly, as recommended by their healthcare professionals. The home had a named nutrition champion in charge of overseeing nutritional care in the home. Food and fluid charts were kept where people were considered at risk of not eating or drinking enough. These were accurate, detailed and up to date.

People were given enough to eat and drink. The food was freshly prepared and smelt appetising and looked attractive. With the exception of the pureed meals which were not well presented and the staff serving these stirred the different components of the meal together, making the meal appear less attractive and mixing the tastes together so the person could not enjoy the individual tastes. People told us they liked the food. The staff encouraged people to eat and offered them choices at the point of service. Throughout the day people were given a choice of hot and cold drinks, including milkshakes. Not all bedrooms had been supplied with jugs of water, but people in the lounges were given regular cold drinks. The manager told us that risk assessments were in place for people who did not have a jug of water in their room. People were offered condiments with their meals but these were not always supplied for people to help themselves. People told us they could request snacks and sandwiches outside of mealtimes and overnight and the staff confirmed this. Special diets were catered for and the kitchen made gluten free cakes, although they presented these on the same plates as other cakes therefore risking contamination. There was a good choice of cooked breakfasts, porridge, cereals and toast. People told us food was served in large portions and they could request more if they wanted. People told us they were able to choose alternatives to the meals on offer and their different tastes were catered for. They were able to discuss food likes and the menu at regular resident meetings.

People's health care needs had been assessed and recorded. We saw that these were monitored. A doctor visited the home weekly and people could request other home visits. We saw evidence that people saw a range of health care professionals to meet their needs. We met a visiting professional on the day of our inspection. They told us the staff were prompt at referring people whose healthcare needs changed or when people became ill. They told us the staff followed their guidance and advice.

Good

Is the service caring?

Our findings

Some of the things people told us were, ''the staff are all lovely and kind'', ''I cannot fault them'', ''nothing is too much trouble for (the staff)'', ''Staff are good, you always get the odd one who isn't'' and ''Staff are kind.''

Relatives also told us the staff were kind and caring. They said that they were approachable, calm and treated people with respect.

We observed the staff being kind and thoughtful. They approached people calmly and showing respect. They asked people for their opinions and allowed them to make choices. The staff bent down to speak with people and listened to what they had to say. In two different instances we saw that people became upset. The staff responded kindly, offering physical and emotional comfort and reassuring the person. When staff supported people to eat, they did so in an unrushed way, allowing the person to take time and make choices. The staff knocked on bedroom doors before entering and addressed people by their preferred names.

People were dressed in clean clothes, with clean hair and nails. However, two people told us that they sometimes found their relatives in soiled clothes or with dirty hands. One visitor said they did not know whether or not their relative had regular showers or baths. The staff told us they tried to offer people a bath or shower each day but this was not always possible because of staffing levels

The staff told us they liked working at the home. They spoke fondly about the people who they cared for. They knew people's interest and personalities. The staff told us they worked with families to make sure they identified and met people's needs. One member of staff told us, ''their families are all part of our big family.'' Visitors were able to visit whenever they wanted and to be involved with caring for people, for example supporting them to eat a meal.

Requires improvement

Is the service responsive?

Our findings

The provider employed two activities coordinators who planned and facilitated organised activities. They spoke about some of the special events they had organised and said that people had enjoyed these. On the day of our inspection a clothes shop was visiting and people could try on and buy clothes. There was a regular church service and art and craft groups. There was a film shown on a big screen twice a week. There was a coffee shop where they held regular fish and chip suppers. However, people throughout the home told us they did not always know what the planned social activities were and said they would like more information. There were notice boards for people which included information about social activities, but these were not up to date and some of the information was hard to read.

The activities organisers told us they were creating life stories with families, to give the staff more information about people's backgrounds, interests and hobbies.

People on the first floor told us the staff were often too busy to spend time with them and they said that they did not always have enough to do. There were boxes of crafts, jigsaws and activities, but people said they did not know if they could use these and the staff did not always offer them. People told us about some of their interests, but when we spoke with the staff who were supporting them, they were not aware of these and told us different information about the person which was not true. On the ground floor we saw the staff spending time talking with people, dancing, singing and helping them with crafts and other activities. The staff knew people's interests and hobbies and told us they tried to allow people to follow these interests.

People's care needs had been assessed by senior staff before they moved to the home. One of the team leaders told us they tried to involve care staff in the assessments as well because this was useful for them to get to know the person. The team leaders then created care plans which included information on their different needs and how these could be met. Care plans were reviewed and updated monthly and we saw that information was updated when someone's needs changed. The staff recorded the care they had given to each person daily and this reflected their assessed needs.

People told us they knew how to make a complaint and who to talk to if they were unhappy about anything. There was a record of formal complaints and the action the provider had taken to investigate and to respond to these.

Requires improvement

Is the service well-led?

Our findings

During this inspection we identified risks to people's health and safety. The provider took action following our inspection to mitigate some of these risks. Before our visit they had identified that short notice staff absences had an impact on people's wellbeing and had taken action to try to reduce the risks associated with this. However, people living at the home and the staff reported concerns to us which showed that people were still at risk and that their needs were not always met. For example, one person was being given food which was not the right texture for them and this presented a risk of choking. The staff told us they did not have time to read people's care plans and did not know people's needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt the home was well-led and organised. People told us they could speak with the managers or staff if they had any concerns and these were responded to. The staff said that they felt well supported. Some staff felt that managers did not always support them when they were short staffed and finding it difficult to manage the work. However, others said that the managers spent time on the units and offered hands on support when they needed. The manager told us that she and the deputy manager often walked around the home throughout the day. Some staff told us things had improved at the home and the manager had introduced positive changes.

The registered manager had been in post since 2014. She previously managed another home and had experience working in social care. The manager had undertaken a leadership in management of care award. The provider, Care UK, is a national organisation operating 104 homes throughout England and Scotland. The organisation's regional director regularly visited the home offering support and carrying out audits.

The provider, manager and staff undertook a large number of audits covering all aspects of the service. These included audits of records, the environment, staff training and support, pressure areas, health needs, accidents, incidents and complaints. The manager created a report on the service each month and Care UK had developed a quarterly audit which looked at whether the service was safe, effective, caring, responsive and well-led in line with the Care Quality Commission inspections. Audits were clear and up to date. There were action plans where shortfalls in the service were identified. The provider had already identified concerns about short notice staff absence from the home and the impact this had on the people living there. They had put in place some measures designed to address this and reduce the risks of this.

Following our inspection visit the manager gave us feedback on how she had started to address areas of concern we identified during the visit, these included specific actions such as updating records and training staff.

The provider asked people living at the home, their representatives and staff for their feedback in written surveys. We saw the results of surveys undertaken in 2015. Where concerns had been identified the provider had produced an action plan, which showed how they were meeting identified concerns. This information was available for people living at the home and visitors in the main foyer.

The London Borough of Hillingdon carried out monitoring visits at the home. We saw the report of their most recent visit. The provider had responded to areas where the local authority had highlighted changes were needed.

The provider had notified the Care Quality Commission (CQC) of significant events, accidents and incidents as required. They had also completed a Provider Information Return for CQC which included information from their own audits and actions they were taking to improve the service.

There was evidence the provider analysed accidents and incidents and took action to prevent the reoccurrence of these.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 registered person did not ensure that care and treatment was provided in a safe way because they did not mitigate all risks.** Regulation 12(1), (2)(b)

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not ensure sufficient numbers of staff were deployed to meet people's needs.** Regulation 18(1)

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had not always obtained the consent of service users to their care and treatment.** Regulation 11(1)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not always mitigated the risks relating to the health, safety and welfare of service users.** Regulation 17(2)(b)