Hill Care Limited

Burton Closes Hall Care Home

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
Burton Closes Hall is a residential care home providing accommodation for up to 58 people who require nursing or personal care. This includes both older and younger adults who may be living with dementia and/or a physical disability. At the time of this inspection, there were a few people with either a learning disability or an enduring mental health condition, with a primary care need of nursing care relating to their physical health conditions. The service provides single room accommodation, including some with en-suite provision over two floors within one adapted building. At the time of this inspection there were 25 people using the service.

People's experience of using this service and what we found
The provider's governance arrangements, were still not effective to consistently ensure the quality and safety of people's care and for timely decision making, risk mitigation and service improvement when needed. Related records were not always accurately maintained.

Risks to people's safety were not always effectively managed and mitigated. Medicines were not always safely managed to consistently ensure people received their medicines when they should and we found risks regarding the provider's fire safety and related emergency arrangements at the service. We were mostly assured the provider was meeting key principles for infection prevention and control at the service, including for COVID-19. However, some areas of environmental and equipment cleanliness were not proactively ensured, until we raised this with the provider.

Staff were safely recruited and understood nationally recognised safeguarding principles and local procedures for people's care. However, staffing arrangements, including areas of training and for staff supervision were not wholly assured. We signposted the provider to help them review and develop their staffing and workforce arrangements for people's care.

People were often supported to have maximum choice and control of their lives. However, the provider was not able to fully demonstrate that decisions made for some people's care with regard to their daily living arrangements, were lawful, least restrictive and in people's best interests.

We expect health and social care providers to guarantee people with a learning disability, respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting any person with a learning disability and providers must have regard to it. The service was not able to fully demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture to ensure individual needs could be fully met.

The provider regularly sought the views of people, relatives and staff. However, timely follow up to address outcomes from this was not always demonstrated. People, relatives, staff and external health professionals

we spoke with were often happy with the service and arrangements for people's care. However, many felt further improvements were needed, to fully ensure the quality and safety of people's care and optimise people's care experience.

Staff were kind, caring, knew people well and had good relationships with them and their families. Staff understood many aspects of their role and responsibilities for people's care. They were responsive, to ensure people's access to relevant external health professionals when needed and regularly provided care in a personalised way. Risks to people's safety associated with their health conditions, were often effectively managed, although we found record keeping anomalies relating to two peoples' nutritional needs we looked at, where risk information was not accurately recorded, to safely inform their care.

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 25 May 2019) and there was a breach of regulation. The provider completed an action plan following the last inspection, to show what they would do and by when to improve. At this inspection sufficient improvements had not been made and we found breaches of regulation in relation to safe care and treatment and governance. The service remains rated as requires improvement. This is based on the inspection findings. The service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
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.

This was a focused inspection prompted by a review of the information we held about this service; to check the provider had followed their action plan to rectify the breaches we found at our last inspection of this service in May 2019, and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led, which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Burton Closes Hall Care Home on our website at www.cqc.org.uk

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safety, management and leadership at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. 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?

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

Burton Closes Hall Care 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
The inspection team consisted of two inspectors and an Expert by Experience, who spoke with people's relatives by telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Burton Closes Hall Care Home is a 'care home'. People in care homes received accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Burton Closes Hall Care Home provides nursing care. CQC regulate both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the 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. At the time of our inspection there was not a registered manager in post. A new manager had commenced on the day of the inspection who was due to submit a registration application to us.

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 local authority and professionals who work with the service. We used the information the provider sent us in their 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 of this information to plan our inspection.

During the inspection
We communicated with five people who used the service and eight relatives about their experience of the care provided. We spent time observing how staff interacted with people and we spoke with seven care staff, including two senior care, a nurse, the deputy nurse manager and the new manager for the service. We also spoke with two senior external managers for the provider. We reviewed a range of records at the inspection visit. This included seven people's care and medicines records; staffing, quality assurance management records and operational policies. Following the inspection, we continued to seek clarification from the provider, to validate evidence found.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People's medicines were not always safely managed. The provider was not able to fully demonstrate that people received their medicines as prescribed, when they needed them.
- Two medicines prescribed for one person, had run out of supply at the service. Staff and the person due to receive the medicines, told us that one medicine had run out the previous day and the other five days before this inspection. The person therefore had not received their medicines as prescribed, when they should.
- During the inspection we saw a relative who visited regularly, found a medicine tablet in one person's bedroom. The most recent record of medicines administered to the person, showed they had been given all of their medicines as prescribed. This meant the provider was not able to demonstrate that staff had given the person's medicines safely to them, when they should.
- Topical medicines administration records we looked at were not always accurately recorded, to show whether and when people's skin creams had been applied by care staff, as prescribed.
- The medicines policy was not specific to the service and referred to tasks that were not carried out at the service. The policy contained unnecessary information. It had not been updated to reflect the recent change from paper to electronic medicines administration record keeping system. Staff were not always following the policy to ensure people received their medicines when they should.
- The provider had recently changed their medicines administration recording from paper records, to an electronic record (e-mar system). Not all staff responsible for people's medicines were trained and competency checked. To ensure they had the skills and knowledge needed to administer people's medicines safely, using the e-mar system.

People were at risk from unsafe care and treatment because the registered provided had failed to fully ensure the proper and safe management of peoples medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The providers risk management strategies were not always effectively operated, to fully ensure people's safety at the service.
- Risks to people's safety associated with their health conditions were assessed before people received care and regularly reviewed. Overall, staff understood the related care steps they needed to follow, to mitigate any risks identified. For example, to help people to move safely. However, staff were not always provided with accurate information, following instructions from relevant external health professionals for two people's nutrition. This meant there was an increased risk to people, of receiving unsafe or ineffective nutrition. We discussed our findings with the manager, who subsequently confirmed their action to rectify

this for people's safety.
● The environment and systems relating to fire safety had not been upgraded or acted on by the provider, following a fire risk assessment of the service completed in April 2021. The fire risk assessment identified a list of fire safety improvements needed, of moderate risk. We referred our related concerns to Derbyshire Fire and Rescue Service (DFRS), who visited the service and issued a fire safety improvement notice to the provider. The provider subsequently sent us their fire safety improvement plan agreed with DFRS, with timescales for achievement. We have referred further to this in relation to the provider's failings in their governance systems, under the Well Led section of this report.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
● We were not fully assured the provider was always working within the MCA for people's care at the service.
● We found appropriate external legal authorisations were either sought or agreed for some people's care when needed. However, there were a number of people receiving care, who remained in their own bedrooms, continuously throughout the day and night. Staff told us that because of their health conditions, those people were not able to give their individual consent to this arrangement for their care. Their individual care records did not show how the related decision had been made for each person's care, who was involved and whether the decisions were lawful and in people's best interests.
● We discussed our findings with the managers for the service. They told us they would review and take the action needed to ensure people's rights and best interests in line with the law. We have referred further to this under the Well Led section of this report.
● Otherwise, we saw positive interactions throughout the inspection, Staff regularly checked people's choices and whether they were happy before they provided care and support.

Staffing and recruitment
● Staffing arrangements did not always ensure the delivery of timely care, training and staff supervision.
● We observed staff did not always respond in a timely manner when needed, to people's call bells for assistance. People were sometimes left unsupervised in communal areas for long periods. This included people who, because of the health conditions, were identified at risk of falls, or could easily become distressed and behave in a way that was challenging for themselves or others around them. Management monitoring of real-time call bell responses was not regularly ensured, to help check and inform staffing arrangements at the service.
● We found gaps in staff training and supervision arrangements, which related records showed. Examples of training gaps included, relevant fire safety training, dementia care and relevant learning disabilities and mental health needs training; and to ensure timely care certificate completion and access to relevant national vocational qualification training.
● Many people, relatives and staff, felt staffing levels were not always sufficient, to enable people's needs to be met in a timely manner. Examples of their comments included, "There are just about enough staff to do the basics, but nothing else; they just rush in and out." "It's a bit short staffed". "You can be waiting too long for drinks, call bell to be answered and sometimes the toilet; the staff do their best."
● Staff were safely recruited. Relevant pre-employment checks were carried out before any offer of

employment was made. This included checks of staff pre-employment experience, training and Disclosure and Barring Service (DBS) checks. DBS checks provide information, including details about any convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely.

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

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. General bedroom and mattress cleanliness and hygiene was not proactively ensured. Immediately following this inspection, the manager sent us written assurance of their action completed to rectify this for people's safety.

● 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.

The provider followed government guidance concerned with COVID-19, with regard to visiting in care homes. People's rights to family life and to receive visitors were understood and followed by staff, in line with the most recent government guidance changes in May 2022.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse.
● Lessons learned were not always demonstrated by the provider, to ensure timely improvements when things went wrong at the service; or where important remedial measures were identified as needed for people's safety. For example, the provider had not fully ensured timely fire safety remedial measures, following the service fire safety risk assessment report recommendations of April 2021.
● The provider had sent us required written notifications when things went wrong at the service, to help us check the safety of people's care.
● Staff understood how to recognise, respond and report the abuse of any person receiving care at the service. People and relatives felt overall people were safe at the service. They were confident and knew how to report any safeguarding concerns. All said that staff were kind, caring, respectful and ensured people's dignity when they provided care.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection the provider had failed to operate effective systems to consistently ensure the quality of people's care and to drive service improvement when needed. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made and the provider was still in breach of Regulation 17.

● The provider's governance arrangements were not effectively operated, to consistently ensure the quality and safety of people's care, timely risk mitigation and drive service improvements when needed.
● We found concerns at this inspection, relating to the provider's arrangements for medicines, staffing, nutrition, infection prevention, control/cleanliness and some of the provider's quality and risk management strategies. Such as, for fire safety and related emergency arrangements, and to consistently ensure the Mental Capacity Act (MCA) 2005 was being followed for people's care.
● Environmental health and safety checks of the building were not completed in accordance with the provider's quality assurance policy for health and safety audits.
● Records were not always accurately maintained for the management of the regulated activity. For example, management audits and risk assessments were not always accurately recorded or carried out in line with the provider's own quality assurance policy, to fully ensure the quality and safety of people's care.
● The provider did not always evaluate and improve their practice in a timely manner, in respect of processing information for the quality and safety of peoples' care. Where results from service audits and risk assessments showed improvements were needed, these were not always acted on swiftly, to reduce any risk impact on people from risks identified. There was often no targeted action plan, identifying timescales for achievement, who would be responsible for monitoring and completion and by when. There was no formalised scheme of delegation to fully ensure effective management communication, decision making and accountability for people's care.
● The provider's strategy to consistently ensure high quality care through effective staffing arrangements was not fully assured. Staff were not always effectively informed or supported to perform their role and responsibilities. We found training gaps relating to people's care and safety needs. Staff did not receive regular supervision, to continuously inform and support their performance and development for people's care.

The provider's governance arrangements did not consistently ensure effective risk management, service improvement and related decision making, when needed for the quality and safety of people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The previous registered manager had recently left the service. A new manager had commenced at the service on the day of this inspection. They engaged well with us and the staff team, to support the inspection process. Following this inspection, the manager told us that staffing arrangements were now under review to ensure the effective organisation and timely delivery of people's care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We saw staff were kind, caring and interacted with people in a supportive, respectful manner. There was a positive, cheerful atmosphere at the service. Staff had good relationships with people, knew them well and regularly provided care in personalised way.

● People's views had been obtained by the provider, and also those of staff, but timely follow up to address any issues arising from this, was not consistently ensured. This included acting on recorded feedback from people regarding the quality and choice of meals and ensuring timely feedback and any action needed, from their most recent staff survey carried out in November 2021.

● Regular opportunities were provided for people to engage in home life and a range of social and recreational activities they enjoyed. However, people's equality characteristics were not always fully considered and acted on, to effectively inform their care. For example, to fully and consistently ensure the right care and support for any person living at the service, with a learning disability.

● We received variable but mostly positive comments from people and relatives about the arrangements for people's care and their engagement and involvement in this. Some of their comments included, "Staff are always personable; I am kept informed and any concerns are usually dealt with professionally and resolved." "They listen and have adapted things to suit me." "Staff are always very responsive to any health changes and quick to act." "They need to sort the meals out, they are so uninspiring, bland and repetitive."

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 provider understood their duty of candour. They had sent us written notifications when required to do so, following any important incidents when they happened at the service

Working in partnership with others

● The provider often worked in partnership with relevant authorities and external professionals involved in people's care, including to enable people's access to routine or specialist health screening.

● Action was taken by the manager at our inspection, following a concern raised regarding access to chiropody for routine foot care. Otherwise, people and relatives were positive about the arrangements and support for people to access relevant health professionals when needed.

● During our inspection feedback we signposted the manager and external senior manager for the provider to Skills for Care. Skills for Care is the strategic workforce development and planning body for adult social care in England. They work with social care providers to effect positive change through improvement, workforce development and regulation in social care.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service and others were not fully protected against the risks associated with unsafe medicines management.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 The provider's governance arrangements did not consistently ensure effective risk management, service improvement and related decision making, when needed for the quality and safety of people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a warning notice.