

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

Summary of findings

Overall summary

The inspection took place on 22 January 2019 and was unannounced.

The last inspection of the service was on 27 February 2018, when we rated the service 'requires improvement' for all key questions and overall. Following this inspection, we asked the provider to complete an action plan to show us what they would do to improve the service to at least 'good.'

At this inspection we found that they had made improvements, however some aspects of the service required further improvement.

The Burroughs 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 is for up to 75 older adults, some people were living with the experience of dementia. The provider does not employ nursing staff and cannot meet the needs of people with complex nursing needs. At the time of our inspection 55 people were living at the service.

The service is managed by Care UK, a private organisation providing health and social care throughout the United Kingdom.

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 provider had not always monitored or mitigated the risks to people's safety and wellbeing. For example, we found risks within the environment, which included areas which were not clean and with access to electrical meters and wiring.

The provider's governance systems had not always identified and mitigated these risks.

Some of the support people received focused on the tasks the staff were performing rather than the needs and preferences of the people being cared for. However, we observed that staff interactions were kind and caring. The staff had a good knowledge of the people who they were caring for.

People liked living at the service. They told us their needs were being met and that they were able to make choices about their care and how they spent their time. People had good relationships with the staff, they trusted them and felt safe.

People were supported to take part in a range of different activities and fulfil their particular 'wishes' for special events. The staff had started to support people to be more involved in helping around the service, if this is what the person wanted, such as laying tables and dusting.

Care plans were sufficiently detailed and included information about the risks people were exposed to, people's preferences and how they wished to be cared for and the medical professionals involved in people's care. People had access to healthcare services and the staff worked with these professionals and followed their guidance. People received their medicines in a safe way. They had enough to eat and drink and made choices about the food they ate.

The staff were well supported. There were enough staff to meet people's needs. The provider's recruitment checks ensured they were suitable. The staff had access to training, support and information about their roles and responsibilities. There were appropriate systems for the staff to share information and work effectively together.

The provider had undertaken some work to promote an environment which supported people from the LGBT+ (Lesbian, Gay, Bisexual and Transgender) community. The staff had taken part in the London Pride march where they highlighted some of the issues for older people identifying as LGBT+. They had also had special events to celebrate diversity and encourage people to discuss their identity in a non-judgemental environment.

The provider had systems for monitoring and improving the quality of the service. There was evidence of improvements and the registered manager had introduced new ideas and initiatives which had helped to make the service better. People using the service, staff and other stakeholders were consulted about their views. The provider listened to people and acted on complaints. They learnt from incidents and accidents so that improvements could be made.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment and good governance. You can see what action we have asked the provider to take within our table of actions at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

Some aspects of the service were not safe.

The provider had not always mitigated risks to people's safety because areas of the building were not always safely maintained or clean.

People received their medicines safely and as prescribed, but not always on time.

The provider had assessed risks to people's safety and wellbeing based on their individual needs, and there were plans to support people in a safe way.

There were systems and processes designed to safeguard people from abuse.

There were enough suitable staff employed to keep people safe and meet their needs.

The provider had systems for learning from accidents and incidents, so that improvements to the service could be made.

Is the service effective?

Good ●

The service was effective.

People's needs and choices were assessed so that care could be delivered to meet these needs.

The staff had the information, support and training needed to deliver effective care.

The adaptation and design of the building met people's needs.

The provider acted within the principles of the Mental Capacity Act 2005 to ensure that people consented to their care, or that decisions about this were made lawfully and in their best interests.

The staff supported people to access healthcare services and meet their health needs.

People had enough to eat and drink.

Is the service caring?

Some aspects of the service were not caring.

Some staff focused on tasks they were performing and did not always notice the needs or choices of the people who were being cared for.

However, all of the staff were kind and interactions with people were respectful.

People were able to make choices about the way they were cared for.

Requires Improvement ●

Is the service responsive?

The service was responsive.

People received personalised care which was responsive to their needs.

People's concerns and complaints were listened to and responded to, in order to improve the quality of the service.

People were given the support they needed at the end of their lives.

Good ●

Is the service well-led?

Some aspects of the service were not always well-led.

Not all risks to people's safety and wellbeing had been mitigated.

The provider's governance systems had not always been effective as they had not identified these risks.

However, there had been improvements to the service, including the effectiveness of audits and the way the service was managed.

The provider worked alongside others to review the service and make improvements.

The provider asked people using the service, staff and other stakeholders for their views.

Requires Improvement ●

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 January 2019 and was unannounced.

The inspection team consisted of two inspectors, a member of the CQC medicines team and two experts-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

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report, the provider's action plan and notifications we had received. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

We also looked at public information about the service, such as information on the provider's own website, care home review websites and other public information.

We spoke with the local authority who commission care with the service and monitor the quality. They gave us feedback from their monitoring visits.

During the inspection we spoke with 17 people who lived at the service and two visiting relatives. We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We also spoke with the registered manager, deputy manager, team leaders, care assistants and other staff, including the cleaners, maintenance worker and activity coordinators. The regional director and operations support manager visited the service during the inspection and we spoke with them. We looked at the care

records for six people, records of recruitment and support for three members of staff, staff training records, records of complaints and other records used by the provider in managing the service, such as audits and action plans.

The member of the CQC medicines team looked at how medicines were managed, including records, storage, administration and systems.

We inspected the environment and equipment being used. We also looked at records relating to the provider's checks on health and safety and cleanliness.

At the end of the inspection visit we gave feedback about our findings to the registered manager, operations support manager and regional director.

Is the service safe?

Our findings

At the inspection of 27 February 2018, we found some risks to people's safety and wellbeing had not been mitigated.

At the inspection of 22 January 2019, we again found that some risks had not been mitigated. For example, we found a cupboard containing electrical meters and wiring had not been secured. The registered manager said that this was the fault of contractors working at the service. However, the door had not been checked by staff and remained unlocked for the duration of our inspection. The cupboard was situated in a corridor used throughout the day by people using the service. Whilst there was a sign stating the door should be locked, there was no warning of potential danger and the door could have been opened by mistake.

We saw staff cleaning the building throughout the day, however we found evidence that sufficient cleaning had not always taken place. For example, we found the bath chair in one bathroom had dried brown matter on it. According to the records in the bathroom, this had not been used for two days. This was particularly concerning as there had been an outbreak of diarrhoea and sickness at the service earlier in the month. In another bathroom we found used and uncovered razors and a pair of disposable gloves which had been worn and left on a shelf. Some of the equipment used to help people access toilets had not been sufficiently cleaned.

The provider's own audits of the service included a regulatory governance review, which took place in December 2018. The report of this review identified that commodes were not always sufficiently cleaned and that improvements were needed with 'deep cleaning.' These improvements had not been fully made or sustained because we found a repeat of these concerns at our inspection visit.

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

Following the visit, the provider sent us an action plan explaining the steps they had taken to reduce the risk of these incidents reoccurring.

At the inspection of 27 February 2018, there was not always evidence that staff had learnt from incidents to prevent these reoccurring.

At the inspection of 22 January 2019, we found improvements had been made. The registered manager had developed new systems for recording all accidents, incidents, falls and infections. The records included an analysis of what had happened and preventative action which had been taken. For example, people who had regular falls or were at risk of falling had been referred for support from healthcare professionals to look at ways for them to be safer. Individual risk assessments had been updated to reflect changes in people's needs and their plan of care so that the staff were aware of how best to support the person.

The registered manager had also developed systems for monitoring changes in people's condition or

weight, so that the staff could intervene and provide the right care before people became unwell or had an accident. There was evidence that healthcare professionals had been consulted when this was needed.

Information about these incidents and accidents was shared with the provider, along with information about the action taken by the staff. The registered manager also attended meetings with other managers to share their experiences and learn from each other, so improvements could be made at the service to prevent adverse incidents.

People using the service told us they felt safe there. Some of their comments included, "Of course I feel safe", "I am sure I am safe here" and "I am well looked after, and I feel safe." They felt there were enough staff and they were available when they needed them.

People received their medicines as prescribed, including controlled drugs. The staff allocated to administer medicines wore tabards instructing others not to disturb them. However, they commented that they did still get disturbed and, as a result, sometimes the medicines rounds took longer than expected, meaning some people did not receive their medicines at the allocated time. The staff were careful to ensure any time specific medicines were administered on time. But one person we spoke with told us they sometimes waited for their medicine. On the day of our inspection they said they had waited for over 40 minutes for pain relief and that this was normal. We discussed this with the registered manager who agreed they would look at ways to support the staff administering medicines so they were not disturbed and so that people received their medicines on time.

We looked at 15 Medicines Administration Record (MAR) charts and found no gaps in the recording of medicines administered, which provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed. We found that there were separate charts for people who had patch medicines prescribed to them (such as pain relief patches), insulin administration records and also topical medicines. These were mostly filled out appropriately by staff. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this (in line with national guidance). Running balances were kept for all medicines which had a variable dose (for example one or two paracetamol) and there was a record of the exact amount given. We found that antibiotics were given at the correct doses for the appropriate length of time as specified by the prescriber. Also, for people taking inhalers we saw records to indicate the number of puffs they had received from each inhaler and this was in line with the prescriber's instructions.

All prescribed medicines were available at the service and this assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines. Medicines were stored securely in locked medicines cupboards or trolleys, and immobilised when not in use.

Current fridge temperatures were taken each day (including minimum and maximum temperatures). During the inspection (and observing past records), the fridge temperatures were found to be in the appropriate range of 2-8°. Room temperatures were also recorded on a daily basis. This assured us that medicines were stored at appropriate temperatures.

Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by the local community pharmacy. Controlled Drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities carried out by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour was not controlled by excessive or inappropriate use of medicines. For example, we saw ten PRN forms for pain-relief/anxiety medicines. There were appropriate protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have its intended benefit.

The staff responsible for administering medicines had been trained and their competency was regularly assessed. We saw a member of staff giving medicines to a person and were assured that staff had a caring attitude towards the administration of medicines for people.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider including the safe storage of medicines, fridge temperatures and stock quantities on a monthly basis. A recent improvement made by the provider included ensuring that all PRN protocols were up to date and were reviewed on a regular basis. This had been highlighted from a previous audit which had stated that not all PRN protocols had been updated. This showed the provider had learned from medicines related incidents to improve practice.

The provider had systems and processes to help protect people from abuse. The staff received training in safeguarding adults, and there was information about reporting and recognising abuse posted around the service. The staff were able to describe what they would do if they were concerned that someone was being abused.

The provider had worked with the local safeguarding authority to help protect people following allegations of abuse, and to investigate these.

The staff had developed individual risk assessments for each person. These included risks associated with their physical and mental health, skin integrity, assisted moving, nutrition, choking risks and personal evacuation plans. The assessments were based on a standard set of questions resulting in a score which indicated the level of risk for the person. The plans for mitigating these risks were personalised and indicated where people had specific needs or preferences. The risk assessments were reviewed each month and had been updated following incidents or changes in people's needs.

The provider undertook regular checks on the safety of the building and equipment being used. There were monthly health and safety meetings to discuss any risks within the environment and changes which needed to be made.

There were enough staff to meet people's needs and keep them safe. People told us that staff were available when they needed them. We observed the staff were attentive and regularly made checks on people who were not in the main communal areas. People told us that call bells were answered when they used these.

The staff told us that they thought there were enough of them on duty. They said that they did not feel rushed and had time to carry out their duties.

The provider undertook recruitment checks to make sure the staff were suitable. These included details of a full employment history, references from previous employers, checks on any criminal records from the Disclosure and Barring Service, checks on staff identity and on their eligibility to work in the United Kingdom. They also carried out formal interviews at the service. New staff completed an induction, which included training, shadowing experienced staff and an assessment of their skills, knowledge and

competencies.

People using the service told us they felt the home was clean. Their comments included, "My room is definitely clean" and "It is clean here, they are always cleaning." The staff were provided with protective equipment, such as gloves and aprons. They had received training in infection control and hand hygiene.

Is the service effective?

Our findings

At the inspection of 27 February 2018, we found that consent to care and treatment was not always sought in line with legislation and guidance.

At the inspection of 22 January 2019, we found improvements had been made. There was evidence that people had been consulted about their planned care and had made decisions about this. People were consulted about individual choices each day and this was recorded in their care records.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where people lacked the capacity to make decisions about their care, the provider had consulted with others to make decisions in their best interests. They had made applications for DoLS authorisations and followed any conditions set out as part of these. The provider had details of the legal representatives for each person and kept a record of their involvement in decisions.

People's needs and choices were assessed before, or when, they moved to the service so that care could be planned to meet these needs. The assessments included an admission checklist which ensured that certain assessments relating to risk were completed within the first six hours of a person moving to the service. Other assessments were completed within 24 hours and seven days of moving to the service. The assessments included information about people's healthcare needs. The assessments were used to develop care plans and included information about people's preferences and wishes.

The staff had the information, support and training they needed to deliver effective and safe care. All new members of staff took part in an induction which included training in line with the Care Certificate and shadowing experienced members of staff. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Throughout the staff induction, their skills and knowledge were assessed. The staff took part in regular ongoing training.

The staff told us they felt supported. They felt that the registered manager had given them more direction and delegation. They felt they worked better as a team and communicated effectively with each other. The staff were provided with information about the service through handbooks and online portals. They had access to the policies and procedures and information about their roles and responsibilities. There were regular handovers of information where the staff discussed the service. However, some staff said that these were not always operated effectively and they had not always been told important information about individual people they cared for after a period of leave or absence. We discussed this with the registered

manager so they could address this.

There were regular meetings for the management staff to discuss the service. All of the staff had opportunities to meet with the registered manager to speak about their performance and any training needs they had.

People's individual needs were being met by the adaptation, design and decoration of the premises. The regional director told us that improvements to the décor, lighting and furnishing were planned in the near future. People had their own bedrooms with en-suite facilities. They had equipment they needed, such as hoists, specialist beds and mattresses, hand rails and accessible baths and showers.

There were a number of communal rooms, some of these had been adapted for a specific purpose, such as an art room and a coffee shop. These rooms and the corridors included features designed to promote interest and interaction, such as tactile wall décor and themed pictures.

There were information boards throughout the service, showing people photographs of special events, adverts for future activities and information about how to make complaints.

The staff supported people with their healthcare needs and access to healthcare services. The GP visited the service each week and the staff recorded information to be shared during this surgery. The registered manager told us they came more often if needed. The provider did not employ nursing staff, so the community nurses visited a number of times each day and had a clinical room set aside for their use. There was evidence of consultation with these and other healthcare professionals and their guidance had been incorporated into care plans.

People's individual healthcare needs were clearly recorded, and the staff had information about different medical conditions and the support people required with these.

The provider had received positive feedback from some of the professionals they had worked with. An email sent to the registered manager in November 2018 from a community nurse said, "I want to put in writing the [team's] gratitude for the care [person] is receiving from the home staff. Given [their] multiple risk factors for pressure damage this is a wonderfully unexpected surprise. It is clinically evident that due to such care the extensive pressure ulcers this [person] has are improving." Another healthcare professional also gave positive feedback in November 2018, writing, "All staff were very accommodating to provide information about a patient's functional stats and assisting with physiotherapy sessions. It was a pleasure to see dedication from the staff to assist a patient and improve their mobility. Everyone was great, positive and very helpful."

People were supported to have enough to eat and drink.

Most people liked the food. Their comments included, "It is pretty good. You can ask for snacks, get biscuits and cakes any time of the day", "The food is very nice", "It is lovely", "The food is fine, and I have a balanced diet" and "The food is not bad."

People's dietary needs were recorded in care plans. These plans included information about specialist diets. There was evidence the staff had consulted with other professionals, when needed, to create individual plans. The kitchen staff had the information they needed about people's preferences and specialist diets.

There was a choice of meals which were well advertised, and we saw the staff offering people choices

verbally and showing them the prepared food so they could see what this looked like before making a choice. The staff had information about providing fortified meals and supporting people to eat enough. They demonstrated a good knowledge of how much, and what, people liked to eat. For example, they ensured portion sizes reflected people's individual tastes, they offered snacks and alternatives where people did not want the main choices, and they were able to tell us when and what people liked to eat.

The staff recorded everybody's food and fluid intake and monitored this. The registered manager had introduced new 'hydration stations' which were areas where people could help themselves to or be offered a range of different drinks. These stations included information about why fluid intake was important and how to enhance this.

People were regularly weighed and changes in their weight were shared with the registered manager so that they could ensure appropriate action was taken. For example, increasing the frequency of monitoring, making referrals for external healthcare input and changing people's diet.

Is the service caring?

Our findings

At the inspection of 27 February 2018, we found that whilst interactions between staff and people showed kindness and compassion, people were not always enabled to make decisions about their care.

At the inspection of 22 January 2019, we found improvements had been made. There was evidence that people were consulted when their care plans were developed and reviewed. The records of care also showed that people had been given choices each day. We saw evidence of this and people confirmed they were able to get up and go to bed when they wanted, eat what they wanted, choose how to spend their time and have baths or showers when they wanted.

During our inspection we witnessed kind and caring interactions. However, there were a number of incidents which indicated the staff had focused on tasks rather than the people they were supporting. For example, we observed one person spent over half an hour sitting with food on their face and clothes and another person sitting for the same length of time with their stomach exposed because of the position of their clothing. Both people were seated in an area which was well staffed, and the staff spent time walking past these people, but did not notice or offer support to address these issues. During lunch, we witnessed a member of staff supporting someone with their meal. A large amount of food was deposited on the person's face and it took over ten minutes for the member of staff to support the person to wipe this off their face. Whilst we observed the staff respected people's privacy when delivering care, such as carrying out care tasks behind closed doors. We overheard some staff speaking about the people who they were caring for in rooms where other people could also hear this.

We discussed these observations with the registered manager who agreed to share our findings with the staff so they could learn from these. Following the visit, the provider sent us an action plan which showed they had taken steps to reduce the likelihood of these incidents reoccurring.

We also witnessed kind and positive engagement between the staff and the people who they were supporting. For example, we saw a member of staff spend time searching for a particular kind of music a person had requested so they could play this, we overheard the staff being kind, gentle and thoughtful in their approach asking people's permission to do something and explaining what they were doing and we saw the staff sitting with people holding hands and reassuring them.

People using the service told us they thought the staff were kind and caring. Some of their comments included, "The staff are quite nice people", "The staff are nice and they care", "I am happy here and the staff are good", "You couldn't have nicer carers", "They are all nice and there is a good comradery and everyone knows each other" and "They are very good."

The registered manager had introduced some new initiatives designed to promote individual choice as well as supporting people to be more independent and feel valued. For example, they encouraged people to be involved in household chores, if this was their choice, such as helping to lay tables, make beds, dust and clear away after meals. We witnessed one person making a choice to tidy up jugs of drink in the middle of

their meal. The staff supported this and allowed the person to carry out this task before reminding them that they may wish to finish their lunch. Another initiative was a "wish tree" where people could request a specific special event or 'wish' and the staff facilitated this where possible. For example, one person was being supported to regularly visit a relative who was dying. This showed respect and understanding for what was important for this person.

People's religious and cultural needs were respected and promoted. The registered manager told us that most people were from a white British background and were either Christian or did not follow a faith. Some people were supported to attend local churches and services were also held at the home.

The provider had undertaken some work to promote an environment which supported people from the LGBT+ (Lesbian, Gay, Bisexual and Transgender) community. The staff had taken part in the London Pride march where they highlighted some of the issues for older people identifying as LGBT+. They had also had special events to celebrate diversity and encourage people to discuss their identity in a non-judgemental environment.

Is the service responsive?

Our findings

At the inspection of 27 February 2018, we found that people were not always consulted when care plans were reviewed to take account of changes in how they wished to be cared for.

At the inspection of 22 January 2019, we found improvements had been made. There was evidence that people's preferences were recorded in their care plans. The staff reviewed plans each month with the person when they were allocated as 'resident of the day.' This meant that different departments within the service spent time speaking with the person and reviewing their care, for example making sure their dietary needs and choices were being met, discussing their participation in social activities and making sure their health and personal care needs were being met.

The care plans we viewed were appropriately detailed and gave clear instructions for the staff about how people should be cared for. There was also a 'one page profile' which gave a summary of people's needs, what was important to the person and what people liked and admired about the person. The staff kept records of the care which had been delivered and these reflected care plans. People told us that their needs were being met and they were offered choices.

The provider employed two activities coordinators to organise and facilitate activities. There were planned groups, which included visiting entertainers, craft activities, games, music and quizzes. There were also regular trips out for lunch, to church and the provider was organising a trip to the sea side. One of the activities coordinator told us that they were reviewing the schedule of planned activities. They were speaking with everyone about their hobbies and interests and trying to organise groups of people with shared interests. Following the visit, the provider sent us an updated schedule of activities which showed a plan for each person which reflected their individual choices.

People gave us mixed views on the current activities at the service. Some of their comments included, "We have a good sing, and do quizzes", "I like the music here", "I like the visiting bird man", "Sometimes I do the exercise with the others", "The activities bore me silly" and "Sometimes you get bored, but you have to fight it."

There were monthly meetings for people who used the service to share their views about the service, including upcoming events, planned activities, food, décor and their ideas for improvements.

The registered manager had kept photographs of different activities and special events. These were displayed on notice boards and in folders in the entrance foyer.

The provider responded to complaints and concerns by investigating these and making changes to the service as a result of these. People told us they knew who to speak with if they had concerns and felt these would be addressed. The complaints procedure was displayed on notice boards around the building, although we noted that these were in small print and the information was not always easy to access or clear.

The provider kept a record of complaints and how these had been responded to.

The staff had spoken with people about their wishes regarding end of life care and any special arrangements at the time of or after their death. Their wishes had been recorded. Some people were, and had, received palliative care from the service. The staff worked closely with other professionals to make sure people's needs were being met. There were detailed plans which explained how people needed to be cared for at the end of their lives and who to contact to make sure they had access to additional support and pain relief when needed.

Is the service well-led?

Our findings

At the inspection of 27 February 2018, we found that the systems and processes for monitoring and improving the quality of the service were not always effective. There was not a full-time manager in post and the staff did not always have the leadership and support they needed to provide an effective service.

At the inspection of 22 January 2019, we found improvements had been made. However, we identified risks to people's safety and wellbeing which had not always been mitigated. The provider's health and safety checks had not identified these concerns, so they could make the necessary improvements. For example, an unlocked electrical meter cupboard and areas where there was a risk of infection spreading. There were also instances when people did not always experience a good quality service because the staff who were supporting them did not provide care centred on the person's needs or wishes. The provider's arrangements to supervise the delivery of care had not identified these issues so they could be put right.

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

However, there were also notable improvements at the service. The provider had recruited a manager, who had registered with the Care Quality Commission. They were experienced and had a vocational qualification in care management. They had introduced a range of changes, such as better monitoring of the service, improvements to staff allocation and support, more involvement from people using the service and acting on incidents, accidents and concerns.

The provider also sent us a detailed action plan outlining the steps they had taken following the inspection visit to make further improvements at the service.

The local authority's quality monitoring team carried out visits to the service. They reported that they felt there were positive improvements and that people were receiving the right care and support.

People using the service told us they felt it was well managed. They liked the registered manager and felt confident speaking with them. The staff also told us they felt the service was well managed. Some of their comments included, "I really enjoy having [the registered manager] around she knows what she wants and will try and make it happen", "It's alright now, a lot of improvement here", "The staff management relationship has improved a lot. Before the new management we didn't see them but now when we start at 8:00 they are there. They tell us when we need improvement and they come to the lounge and you can ask for help if you have a problem. They ask if everything is alright, if you have a problem they assist you", "Management is brilliant, they would help if you had a problem. I would go straight to [registered manager] or [assistant manager] they are very understanding", "Much improved, [registered manager and assistant manager] more hands on and lots of positive changes", "Staff morale is up now", "[Registered manager] checks things are place" and "The service has changed for the better, definitely for the better."

A care home review website which rated homes based on feedback from people using the service and their

representatives had received 15 reviews since the last inspection giving a positive rating. Some of the comments from this website included, "Wonderful staff, treat every resident with dignity, respect and patience. Spotlessly clean", "The care home needs an update, the staff are fantastic but need more time for caring and less for paperwork", "I have been particularly impressed with the staff. They are all very friendly and helpful, I feel that [my relative] is being well looked after", "All staff are friendly, polite and professional. [My relative] is safe and comfortable", "[My relative] has been unwell and they have bent over backwards, getting appointments to help [them] and follow this through", "[My relative] has been in The Burroughs for four years and I have found the staff to be very caring, attentive and thoughtful. My only concern would be for the times there have been staff shortages both for the staff and residents" and "Very pleasant home staff very friendly and helpful. Keeps family informed of any changes of relative."

There were a number of different audits carried out by the staff, registered manager and senior managers. These included a full audit of the service by the provider's regulatory governance teams. The last one of these took place in December 2018. The findings of this team were largely positive, although they had identified an issue with deep cleaning and infection control. The registered manager created action plans for this and in response to other audits, which outlined how any concerns would be addressed.

The registered manager said they felt supported by the provider and their line manager. The operations support manager and regional director visited regularly and carried out their own checks on the service. These included speaking with people using the service and staff, reviewing accidents, incidents, changes in weight and the use of certain types of medicines.

The registered manager also worked closely with other registered managers who worked for Care UK and within the London Borough of Hillingdon, sharing ideas and learning from each other's experiences.

There was evidence that all accidents, incidents, falls, infections and other adverse events were analysed and there was learning from these. The staff took part in regular meetings and were invited to discuss different policies and procedures to make sure they were familiar with these. There were management meetings three times a week to discuss any changes at the service.

People using the service and other stakeholders were invited to complete satisfaction surveys once a year. They were also able to provide anonymous suggestions for improvement. Each day at 3pm, all of the staff and managers were asked to stop non-essential work so they could sit and talk with people using the service. This allowed people to have informal discussions about themselves or how they felt about the service.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person did not always ensure that care and treatment were provided in a safe way to service users because they had not always done all that was reasonably practicable to mitigate risks to their health and safety.</p> <p>Regulation 12(1) and (2)(b)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered person did not always effectively operate systems and processes to identify and mitigate risk or to monitor and improve the quality of experience for service users.</p> <p>Regulation 17(1) and (2)(a) and (b)</p>