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

Summary of findings

Overall summary

We inspected the service on 6 March 2018. The inspection was unannounced. Burton Closes Hall Care Home 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. Burton Closes Care Home accommodates up to 34 people in one adapted building. At the time of our inspection 34 people lived at Burton Closes Care Home.

At the time of our inspection there was no registered manager in post, however the manager had applied for registration and was registered on 4 April 2018. They were present at the inspection. The 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. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was enough staff available to meet people's basic needs. The service was reliant on agency staff and people were not always happy with this. Care was not always personalised and people did not have their needs and wishes beyond basic needs met.

Staff had been trained in safeguarding and understood how to raise any concerns. Recruitment processes were in place to ensure any new staff would be subject to pre-employment checks on whether they were suitable to work at the service.

Appropriate arrangements were in place for medicines management and these followed procedures designed to ensure safe medicines practice. People were offered their medicines as prescribed.

Processes were in place to ensure risks and people's health needs were assessed, managed, monitored and responded to. The premises had been adapted in ways to make sure it was suitable for people using the service. However this was not always successful leaving some people cramped in small communal areas and others isolated in very large communal areas.

People's needs and choices were promoted in a way that prevented and reduced the impact of any discrimination. People's communication needs were assessed and people were supported to communicate effectively with staff. The Accessible Information Standard was being met. Staff knew how to support people to make decisions and ensure their rights were respected, working in line with the principles of the Mental Capacity Act 2005.

Due to the high use of agency staff people were not always supported to have maximum choice and control of their lives.

Staff in post were trained and were well supported. Staff were caring in their interactions with people.

However care was not always delivered in a manner that promoted people's dignity and independence. People were not offered the opportunities to pursue their different interests and hobbies and contact with the local community was poor.

People felt able to raise any issues or concerns. There was a complaints process in place to manage and respond to any complaints should they be made. The service had received many compliments.

The manager was aware of the issues to be addressed and had started to make progress on recruitment and more stimulation for people. The provider and the manager had audits and checks in place to provide assurances for the governance of the service. Policies and procedures had been updated to reflect the needs of the service.

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 consistently safe.

There was enough staff to ensure people were cared for safely. Medicines were managed safely and actions were taken to prevent and control infections. Risks were assessed and managed. Policies were in place to ensure any new staff would be subject to pre-employment checks.
Staff understood how safeguarding procedures helped to protect people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always offered meals they enjoyed at times chosen by them. People's health, including nutritional needs were monitored and responded to appropriately. People's needs and choices were assessed in a way that helped to prevent discrimination and the principles of the MCA were followed; people's communication needs were assessed and met.
Staff received mandatory training, support and supervision

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always supported because care had not always been taken to ensure they were assisted to be clean and fresh.
Staff were kind and caring in their interactions with people.
People were not always involved in their care planning and how the service met their needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were bored and were not offered a range of interests, hobbies and preferences. The Accessible Information Standard

was being met.
People were able to raise issues and make a complaint which were investigated and responded to appropriately. The service had many complements.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The manager understood their responsibilities for the management and governance of the service, however they had not had time to put this in place and the service lacked direction.

Care was not always personalised.
Systems were in place to monitor and improve the quality of the service.

Burton Closes Hall Care Home

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 6 March 2018 and the inspection was unannounced. The inspection team consisted of one inspector, one specialist advisor in nursing care and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses services for example older people.

Before the inspection we looked at all of the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about.

As some people were living with dementia at Burton Closes Hall Care Home we used 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 talk with us.

We used information the provider sent us in the Provider Information Return.(PIR) This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the local authority commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. The local authority commissioning team had completed a contract monitoring visit since our last inspection. In addition, during our inspection we spoke with six people who used the service

and three visiting relative. We also spoke with the area manager, the manager, one nurse and two care staff.

We looked at three people's care plans and reviewed other records relating to the care people received and how the service was managed. This included risk assessments, quality assurance checks, staff training and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

The provider had systems in place to keep people who lived at Burton Closes Hall Care Home safe from avoidable harm. All of the people who lived at the home and the family members that we spoke with thought that they or their family members were safe living in the care home. People told us they felt comfortable with the permanent staff and all of the people we spoke with could name a member of staff they would speak to if they had a concern. One person said, "I do feel safe here. I need a lot of help and I get it. If I had a problem I'd speak to [member of staff] and she'd sort anything for me." Another said, "Yes I would speak to [staff member]."

Accidents, incidents and near misses were reported. Records showed accidents and incidents were reviewed by the manager and senior manager so that any trends could be identified and actions taken to reduce reoccurrence. This included referrals to the falls clinic and a review of footwear and mobility equipment.

Residents were being assisted to move using a hoist or transferred between wheelchairs and armchairs safely and appropriately. We saw that care staff explained to residents what they were about to do before they provided assistance and also spoke to residents appropriately, providing reassurance where necessary. People who needed a hoist to assist them to move had their own slings. This is important as the size of the sling is designed to fit individual people and reduce the risk of cross infection. Staff told us they were familiar with people's care plans and risk assessments and these were kept under review.

Measures were in place to minimise risks to people at risk of falls. These included alarm mats beside some people's beds, and call buzzers placed within reach in bedrooms and communal areas. During our inspection we observed there was enough staff to meet people's immediate needs and to keep them safe.

Staff were trained to understand and to recognise potential abuse and how to raise a safeguarding alert. Training records and discussions with staff supported this. The provider had systems and processes in place to ensure people were safe. Risks to people were assessed and their safety monitored and managed in a way that promoted their independence and involvement.

People told us they felt safe and had not experienced any discrimination whilst at the service. One person told us, "I don't worry about a thing." Another said, "There is always someone around, so I always feel safe." The manager told us they spend time walking around every day. They said they chat to people about their care needs including their safety. People and staff confirmed this.

Medicines were administered safely. Some people knew what their medicines were for and records showed reviews of people's medicines had taken place with their GP. Medicines were stored safely and were in date. Staff provided people with medicines as and when they needed them. People said staff always tell them what their medicines are for and give them plenty of time to take them.

Staff recorded the medicines that had been administered and the reason why. We checked other medicines administration record (MAR) charts and found these had been completed as required.

The staff member in charge of medicines administration was knowledgeable on the systems in place to ensure people received their medicines safely. These included the processes for ordering, storage and disposal of medicines. Staff had been trained in medicines administration and management. In addition, regular checks on records helped to ensure the proper and safe use of medicines. These actions helped to ensure people received safe care around the management and administration of their medicines. Medicines were managed safely and people's involvement and independence was supported in the management of their own medicines when appropriate.

Records showed fire alarm systems were regularly checked and fire evacuation was practised. Personal emergency evacuation plans (PEEP's) were in place for each person and recorded what support people would require in the event of an emergency evacuation. Risks associated with fire and emergency evacuation were being managed.

The service was clean and fresh and there were systems to ensure the service was cleaned in a manner that protected people from the risk of the spread of infection. Clinical waste was disposed of appropriately. Staff had appropriate protective clothing available to them.

Recruitment records showed pre-employment checks had been completed. We checked the provider's recruitment policy and discussed the recruitment processes with the registered manager. The registered manager provided assurances that all the required pre-employment checks contained in the Health and Social Care Act 2008 for people employed in delivering a regulated activity would be met. Procedures were in place to help ensure staff were suitable to work with people using the service.

Requires Improvement

Is the service effective?

Our findings

People received care and support with their meals and drinks. However, people were not always happy with the quality of the food. People said hot meals were served cold or barley warm. The main meal was in the evening, most people we spoke with did not like this. We were also told the food was boring. For example, one person said, "There's too much repetition with the food. It's always soup and beans and toast, always the same, it's so boring, and not even nice. The soup is like dishwater." Another said, "The food's not bad I suppose. I don't go hungry, anyway." A third said, "The food is OK. Not much to write home about food is cold mostly sometimes it's always only luke warm, never hot".

The menu for lunch was soup which did not look appetising, also a variety of sandwiches, for dessert there was yoghurts, fruit and jelly. We were told the hot option was powdered mashed potatoes and spaghetti hoops. This food was in bowls on the hot cabinet uncovered and were going cold and congealed. People in their rooms had their meals served without covers and no means of keeping them warm between the dining room and their rooms. This resulted in meals that were not always hot and appetising. When we spoke to the manager we were told the breakfast and lunchtime meal had been prepared by a domestic assistant at the home as the cook and kitchen assistant would be on duty later in the day. She explained that the meal had been changed due to work in the kitchen on the gas and extractor fans. However people told us the food was consistently poor and not just on the day of the inspection.

People's dietary and nutritional advice was clear and staff had clear directions. Staff were knowledgeable about people who had special dietary requirements, for example what changes were made for a person who followed a specific diet. Staff monitored people's weights and had taken action when they identified one person had lost weight. Staff sought the advice of a dietician and the person now received a food supplement and staff were continuing to monitor their weight.

The service relied heavily on agency staff. People told us they found this difficult. One relative said, "It takes a long time to get to know [relative] and all their care needs. We have to start all over again when new staff come along. The staff seem to change all the time and it's just not right for [relative]" A person said, "We're always getting new carers, that's not good." A Second said, "We keep getting fresh carers. They're always in circulation. I'd rather have ones I know. The old hands are worth keeping."

People received effective care because staff had the knowledge and skills to do so. Staff told us they received training in areas relevant to people's needs and records showed this covered areas such as first aid, health and safety and infection prevention and control. Staff told us they were supported to obtain training they had identified themselves as relevant to people's needs. For example, one staff member told us they had attended training in dementia awareness as they wanted to know more about dementia. The manager had a system in place to keep track of what training staff had completed and what date it needed renewing. All training was up to date or had a date planned for those who were out of date. The service had provided staff with the skills, knowledge and experience they needed to deliver effective care and support. The nursing staff were supported by an appropriate clinical professional. Staff told us they now received supervision on a regular basis and records confirmed this. Supervision is a way of supporting staff to deliver

good quality care by ensuring their skills are of a high enough standard.

People had their rights protected because staff knew and worked within the principals of the Mental Capacity Act (MCA). The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had policies in place that covered the MCA and making decisions in a person's best interests. When people lacked the mental capacity to make some specific decisions by themselves these had been made in meetings with other professionals and family members when appropriate. These meetings were to discuss what decisions were considered to be in a person's best interests. Where appropriate, applications for DoLS authorisations had been made. People's consent to their care and treatment was sought by staff in line with the MCA.

People's physical and mental health was promoted. Staff also told us if people wanted them to, they would accompany them at appointments with their GP or hospital consultants, they told us this helped them to understand more about people's healthcare needs. However, one relative told us they were never told of their relative's hospital appointments.

People's needs and wishes in relation to their health were clearly recorded in care plans. These had been updated and contained clear concise information for staff to follow. We saw staff were knowledgeable about people's needs, including any health conditions. For example, if a person's skin was at risk of a pressure area staff were directed on how to ensure the skin was protected. This was through the use of pressure relieving cushions. We checked and found people who needed these cushions were in use.

People were supported with their health care and staff worked with other organisations and other professionals to ensure people received effective care. People who used the service and a relative told us the GP came regularly.

Assessment of people's diverse needs, including in relation to protected characteristics under the Equality Act 2010 were considered in people's care plans with their input. This helped to ensure people did not experience any discrimination. This helped to prevent and reduce the impact of discrimination and helped to meet people's needs under the Equalities Act 2010.

The environment was difficult to manage and did not always meet people's needs. Burton Closes Hall was a stately home and some of the communal areas were vast and difficult to have staff available for people. We saw some people were left alone for long periods with staff just doing a pop in check on them. This left people at risk of isolation. However, in the residential area the space was very cramped and some people struggled with this lack of space. There were three small areas for people there. One was used continually and was very cramped with up to ten people using it. None of them had access to a table or anything to hold personal possessions and all mobility aids were left outside the room. This meant people were dependent on staff to assist them to move therefore limiting their mobility and potentially placing them at risk of falls.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always supported because we saw that several people who needed assistance to dress were wearing soiled clothing and some of their clothing was in a poor condition. One resident had holes in their jogging trousers. Some men had not been shaved. One man had dirty long chipped finger nails, no socks on and his trousers were damp and stained. Another person was wearing a badly stained top, this top had been left on throughout the day, and another two people had dried faeces under their finger nails. The majority of people in the nursing area of the service looked unkempt, their hair not brushed and their clothes did not look clean, ironed or fresh.

People we spoke with told us they were happy with their bedrooms. The bedrooms we saw were clean, smelled fresh and were personalised. However, the bed sheets were all very thin and some were see through, due to overuse. There was a shortage of towels and face flannels. We were told these were on order and would be chased up. This lack of basic household linen showed a lack of respect for people who used the service.

Staff were knowledgeable about people who had special dietary requirements. These details were displayed on the wall in the main dining room for everyone to see. While this information is needed by staff, putting it on display in the dining room was detracting from people's right to privacy.

Staff endeavoured to make dining a pleasant experience. The dining rooms in both areas of the service were set to look homely, tables were covered in tablecloths and had flowers, condiments cutlery in place. People were offered napkins. However, we saw one person alone in a large lounge. They were leaning forward in their chair to reach their meal on a coffee table placed to one side, the person did not look to be comfortable or safe. This person had a soft diet due to risk of choking, however there were no staff supervising the person to ensure they ate their food without incident.

People told us and we saw staff knocked on people's door and got people's permission before entering their room. People said staff didn't rush them when they were assisting them to dress.

All the people and relatives we spoke with said the staff were kind and caring. One said, "Of course the girls are kind. They are lovely each and every one." Another said, "They are the best." Our observations supported this view.

The manager had started to ensure people were involved in how the care needs were identified and delivered. There were plans to include people in menu planning and also the time of serving the main meal of the day. At the time of the inspection there was no evidence this was happening or that arrangements were in place to include people.

Requires Improvement

Is the service responsive?

Our findings

People agreed there was enough staff to meet their basic needs in a timely manner. However, other needs and wishes went unattended. For example, one person said, "I don't like to ask the girls for anything else as they are so busy." Another said, "It's not their [staff] fault they just have too much to do." A relative said, "There aren't enough carers to deal with all the people with complex needs. It's not their fault, they're doing their best."

Three people told us that when they pressed their buzzers for assistance sometimes it took some time for the care staff to arrive to provide that assistance and this could be a problem if they needed assistance to get to the toilet though people said this did not happen very often. Three people told us that when they pressed their buzzers, staff came fairly quickly.

There was a high use of agency staff and while the service endeavoured to ensure they knew about people the high turnover of different staff impacted on people's care. Care plans detailed people emotional, religious and psychological needs. However, there was not time for staff to ensure these were understood and met.

People told us they were bored and did not always want to watch television. We were told and we observed this was available to people. The manager was aware of this and was in the process of recruiting an activities organiser to address this issue.

The service had a good hand over system at the end of each shift. This included hand over sheet that contained information on all aspects of people's care and welfare. For example, this showed a picture and description of the type of sling to use should the person need the assistance of a hoist to move. These were filled in at the end of every shift and gave staff necessary and up to date information.

Care plans held information relating to involvement of other medical disciplines, visits and advice. Any changes to care needs, risk assessments or care giving was updated in the plans, which were evaluated and updated if needed on a monthly basis. We saw where possible people and their relatives were included in drawing up care plans and areas such as communication were addressed. This included systems to ensure people who had communication difficulties to use. For example, staff communicated well with people who were living with dementia. We saw the staff made eye contact with the person they were speaking to and spoke slowly and gave people time to respond. However, one family member told us, "[Relative] can't ask for help, they need prompting. You have to get close and ask them how they are feeling frequently. [Relative] needs to get to bed if she's feeling unwell. There isn't always enough staff to do this checking, so sometimes when I come I find her unwell and needing help."

The manager had started to transform the area of the service where people with dementia were cared for. They had introduced a hands-on activities room, where people had access to craft and painting material. They also had decorated a wall with tactile objects people would find interesting to look at and touch.

The service has a complaints policy and process for people to follow. Most relatives we spoke with knew how to use it. Some people were aware of it. However, all people told us they had a member of staff they would feel comfortable to speak with if they had a problem. At the time of our inspection visit there were no outstanding complaints. The service had received many compliments.

Requires Improvement

Is the service well-led?

Our findings

The manager was not registered with the Commission at the time of the inspection visit, however they successfully completed the registration process on 2 April 2018. 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 2008 and associated Regulations about how the service is run. The manager understood when notifications were required and had submitted these as needed. Notifications are changes, events or incidents that providers must tell us about. We also saw the CQC's rating for the service was on display as required.

The manager spoke highly of the staff team and that they were very proud of them, however they were aware of the high use of agency staff and the negative impact it had on people's care and day to day life. They were actively recruiting staff at the time of our inspection visit.

Staff told us they now received regular supervision with the manager where any training and development needs were considered. Supervision provides staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development. The manager had taken steps to ensure staff could approach them, be listened to and took steps to ensure an open and transparent culture. Staff told us the manager was easy to talk to and was aware of the needs of people and said the manager speaks to all the people who live at Burton Closes at least once a day. Staff said they can use this time when the manager is away from the office to get advice and guidance.

Staff we spoke with were enthusiastic and positive about the quality of care they provided. Staff told us communication between different members of the staff team worked well. There was a meeting of all staff every morning to discuss the day ahead and any changes to people's needs, wishes or condition. More formal staff meetings were also held and we saw minutes were taken. Staffs' morale was rising and staff we spoke with said they loved their jobs.

The provider had systems and processes in place that were effective at assessing and monitoring the quality and safety of services and mitigating risks.

Records showed audits were completed on medicines administration record (MAR) charts, fire systems and any reported accidents or incidents. These governance arrangements helped to identify any trends, manage risk and provide assurances on the quality and safety of services for people.

People told us they did not always feel they could influence the service. For example most wanted their main meal in the evening and were not happy with the quality of the food. The manager was aware of this and told us there were plans in place to ensure people were included in meal and menu planning in future.

People and their relatives were positive about the manager. They were in post for five months and it was felt they had made a very positive impact on the service. People and staff confirmed they found the manager

easy to approach and talk with.

Because of the lack of permanent staff the service was re-active rather than pro-active. There was a lack of forward planning and care was task led rather than person centred. People were bored and did not have an active social life. The manager was aware of this and the service was recruiting staff to fill the vacancies.

People told us, and records confirmed other professionals such as health care specialists and social care professionals had been involved appropriately and timely in their care and treatment.