Advinia Care Homes Limited

Burrswood Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Burrswood Care Home, owned and operated by Advinia Care Homes Limited, is registered with the Care Quality Commission (CQC) to provide personal and nursing care to a maximum of 125 people. 75 people were accommodated at the time of inspection.

Accommodation is divided across 3 separate units. These are described by the provider as Peel (providing nursing care to people living with dementia) Kay (providing residential care to people living with dementia) and Crompton (providing general residential care). A fourth unit, Dunster, had previously provided general nursing care but had recently closed

People's experience of using this service and what we found
Medicines were not managed safely which placed people at risk of harm. Medicines could not always be accounted for, which meant these medicines may not have been given as prescribed or misused; it was of particular concern that there was less stock of some medicines which can cause people to be drowsy than expected. Medicines that needed to be taken at specific times were not given safely. Some people were given their night time medicines at teatime on 3 days because there were no staff trained to give medicines working on that unit on those nights.

Management of witnessed and unwitnessed incidents, including falls, was not safe. We found multiple examples where people were known to be at risk, but there had been a failure to act to adequately mitigate those risks. Safeguarding referrals had not always been made to the local authority safeguarding team where people had experienced harm. Deployment of staff was disorganised and frequently chaotic. This was most evident on Peel unit where we found a distinct lack of leadership and management. Staff worked to a 'task-and-time' regime which meant daily routines were operated for the convenience of staff, and not in a person-centred way to best support people.

The food and drink offer across the home was poor. Choice was limited and food was not always nutritious. The needs of people who required a modified diet due to a medical need were not always met. Some people had food preferences based on their religious or cultural background. However, these preferences had been flagrantly ignored by staff.

Induction, training and development of staff was inadequate. There was a distinct lack of qualified nursing staff with the relevant professional training, skills, and experience to effectively deliver nursing care to people living with complex advanced dementia. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The environment, décor and design of the home was not in line with national best practice guidance for supporting people living with dementia.

Whilst it was evident some staff were caring and well intentioned, for others, they appeared indifferent and disinterested. Too often we observed staff not paying attention to basic matters of dignity, privacy and compassion. The individuality and diversity of people receiving care and support was not acknowledged or celebrated in any meaningful way. This was particularly concerning for those people who may have protected characteristics.

The provision of activities and opportunities for people to follow their interests was woefully inadequate. There was too much of an inward focus and links with the local community were virtually non-existent.

There had been a systemic failure of leadership and management across all areas. There was a deep sense of mistrust between staff, the registered manager, deputy manager and senior managers acting for the provider. This led to a closed toxic culture amongst staff which led to poor quality care. There were significant failures in governance, audit, quality assurance and questioning of practice. Governance systems were not operated effectively and were not fit for purpose.

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 06 September 2022).

Why we inspected
This inspection was planned in response to emerging risk based on information of concern received from relatives, intelligence from local stakeholders, and our own analysis risk. Key themes centred on pressure wound care, staffing levels, management of falls/unwitnessed events and leadership and management.

Enforcement and Follow up
We have identified breaches of legal requirements in respect of safe care and treatment, protecting people from abuse and improper treatment, staffing, person-centred care, meeting nutritional needs, dignity and respect, and good governance.

The overall rating for this service is 'Inadequate' and the service is therefore placed in 'special measures'. Full information about CQC's regulatory response to the serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

We are currently keeping the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

In the intervening period between our inspection visits and publication of this report, CQC have worked closely with partners from the local authority, NHS and police to ensure the health, safety and wellbeing of people. This activity remains ongoing at the time 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Burrswood 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.

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.

Inspection team
The inspection was carried out by 3 inspectors, 2 medicines inspectors and specialist nurse advisor.

Service and service type
Burrswood is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Burrswood is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, in the days following the inspection they had resigned. An interim home manager was then brought in to oversee day-to-day operational management.

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 the local authority and professionals who work with the service. We also contacted the local Healthwatch team. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 8 residents and 5 visiting relatives to understand their experiences. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, deputy manager, divisional director, 4 registered nurses, unit managers, 3 seniors, 8 care assistants, administration staff, domestics and catering staff.

We looked at medicines and records about medicines for 25 people, 10 electronic care plans and associated records, training records and information related to safety, audit and quality assurance.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely which placed people at risk of harm.
- Medicines could not always be accounted for, which meant these medicines may not have been given as prescribed or misused; it was of particular concern there was less stock of some medicines which can cause people to be drowsy than expected.
- Antibiotics were not always given safely. One person had been prescribed 2 antibiotics after a visit to A&E but there was an unexplained 4-day delay in staff administering the antibiotics which put that person at risk of their infection worsening. Another person's antibiotic treatment for a chest infection was delayed by 3 days which resulted in them being admitted to hospital.
- Some people's health was placed at risk of harm because their medicines were unavailable or out of stock. One person missed doses of their heart medicine for 14 days and another person was unable to have their regular pain relief for 18 days.
- Some people had swallowing difficulties and were prescribed a thickening agent to add to their drinks to help them swallow safely. The records showed that their drinks were not thickened properly which placed them at risk of developing a chest infection and pneumonia.
- Medicines that needed to be taken at specific times were not given safely. Some people who were prescribed medicines to manage their symptoms of Parkinson's were not given their medicines at the prescribed times, this meant their symptoms may not be properly managed. Antibiotics and other medicines that must be given on an empty stomach were given with food which meant they may be ineffective.
- Medicines prescribed 'when required' were not managed safely or consistently. One person was prescribed a medicine 'when required' to treat diarrhoea, but it was not given when they had diarrhoea. Other people were prescribed medicines to be taken when required but the information recorded to support their safe administration was not personalised and failed to explain how to assess when people needed these medicines.
- When people were prescribed medicine in a patch form, the staff applying the patches failed to record the location of application which meant a subsequent patch could be placed on the same skin area which could cause unnecessary skin irritation.
- Some people were given their night time medicines at teatime on 3 days because there were no staff trained to give medicines working on that unit on those nights.
- The records failed to show that creams were applied properly and, in some instances, showed that staff had applied creams that people had not been prescribed. Creams were not stored safely in people's bedrooms and some people had creams in their rooms belonging to other people increasing the risk of cross infection.

The provider had failed to ensure safe systems for the management and administration of medicines. We found no evidence that people were harmed at the time of the inspection, because the harm is not always immediate, however, people were placed at increased risk of harm by unsafe management of medicines. This demonstrated a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

● Management of witnessed and unwitnessed incidents, including falls, was not safe. We identified multiple examples where people had known to be at risk, but there had been a failure to act to adequately mitigate those risks. For example, 1 person had suffered 8 separate untoward events, some of which required hospital treatment, but there had been a failure to properly risk assess and to make external referrals to appropriate agencies.

● First aid boxes on each unit were not fit for purpose. Single use items were out of date and key items of kit were missing.

● A suction machine in the treatment/medicines room on Peel unit had components missing which meant the device was not fit for purpose. A suction unit is a medical device frequently used in medical emergencies where a person's airway is obstructed.

● In January 2023 staff attended an externally organised workshop to support the use of RESTORE2. RESTORE2 is a physical deterioration and escalation tool for non-acute health and care settings that provides an evidence-based early warning system, which helps staff to recognise and respond when a person may be deteriorating or at risk of physical deterioration. However, the learning and tools from this workshop had not been implemented at the time of this inspection.

● Suitably qualified staff did not routinely obtain baseline physical observations such as heart rate, oxygen levels and blood pressure when people showed early signs of acute ill health. This meant there was no systematic process in place to enable staff to recognise clinical observations that were outside of normal parameters. This, coupled with the failure to implement RESTORE2, exposed people to a risk of harm.

Systems had not been operated effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service, and to properly safeguard people. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

● Safeguarding referrals had not always been made to the local authority safeguarding team where people were at risk of abuse or neglect.

● We identified at least 6 examples where an accident, incident, untoward event or altercations between residents had occurred and not been referred to safeguarding or notified to CQC. Each of the incidents were known to staff but there had been a failure of internal reporting and management oversight.

● On Peel unit, we observed 1 person in a wheelchair, alone in the dining room, exhibiting distressed behaviours for more than 20 minutes. We spoke with a senior carer who told us this person had been placed in the dining room because they had been 'kicking off all morning.' We considered this to be an abusive restrictive practice and instructed staff to properly support this person.

People who used the service were exposed to a disproportionate and unacceptable level of risk with no external scrutiny or oversight. Staff sought to manage behaviours in a manner which constituted an abuse practice. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider used a dependency tool to help ensure enough staff were on duty to people's needs. However, deployment of staff was disorganised and frequently chaotic. This was most evident on Peel unit where we found a distinct lack of leadership and management.

● Staff worked to a 'task-and-time' regime which meant daily routines were operated for the convenience of staff, and not in a person-centred way to best support people.

● We saw how this had a negative impact at critical points of the day. For example, during the medicines round, at mealtimes and when staff took their break entitlement. This also meant there were occasions when communal areas were left unsupervised which meant people were at an increased risk of falls.

The provider failed to ensure sufficient numbers of staff were deployed to meet peoples needs. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relevant pre-employment checks were completed, including with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● Infection prevention and control measures were not consistent or robust. There was a significant malodour on Kay and Peel units during days 1 and 2 of inspection. Peel unit also looked visibly unclean.

● Uniforms worn by staff had recently been changed by the provider. Tunics with pockets had been removed and replaced with simple t-shirts with no pockets. Because the provider did not supply uniform trousers with pockets as part of standard Personal Protective Equipment (PPE), this resulted in some staff carrying their own personal handbag/shoulder bag so they could carry disposable gloves, wipes and a handheld mobile care plan device.

● By carrying these bags from room to room, it posed an infection control risk and a moving and handling risk.

● A scabies outbreak was confirmed at the time of this inspection, but this was not managed well by the provider.

● The provider had been advised by an external healthcare professional to supply staff at risk with appropriate treatment but had failed to do so.

● There was little to no evidence of PPE being used appropriately to support barrier nursing. Staff moved freely between units and people who used the service confirmed as having been infected, continued to mix freely with others.

There was a failure to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care acquired. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

- The food and drink offer across the home was generally poor. On Peel and Kay units, where people lived with dementia, menu choices were restricted. We were told in stark terms this was because people living with dementia 'couldn't make choices' so a 50/50 split of food was sent these units for distribution amongst people.
- In contrast, on Crompton unit, where people were better able to self-advocate, people told us they were offered choice. However, feedback remained negative with comments including "It's just beige food all the time, like chips and pizza. We hardly get any fresh vegetables and I think fresh fruit is considered a treat!" and, "I just don't know how they can consider this food to be nutritious. My [relative] has never eaten this type of food and often doesn't want to eat it. I worry about them losing weight."
- The needs of people who required a modified diet due to a medical need were not always met. For example, for a period, sugar free products for diabetics had been restricted, and we observed staff had been expected to ration a desert intended for 1, between several people.
- Some people had food preferences based on their religious or cultural background. However, these preferences had been flagrantly ignored, for example, pork products had been regularly served to a person living with dementia, despite their care records being explicit this was against their religious beliefs.
- We spoke with key staff across the home to better understand the difficulties and challenges in providing meals to people, and finances was raised as a significant issue. At the time of the inspection the allocated catering budget equated to less than £5 per-person-per-day. Staff reported this made it increasingly difficult to provide people with 3 meals a day, as well as a supper and adequate drinks and snacks throughout the day.

The provider failed to ensure suitable and nutritious food was consistently available to people and failed to ensure preferences based on religious or cultural backgrounds were met. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Induction, training and development of staff was inadequate. We reviewed recruitment and training records for 4 newly recruited staff, including a registered nurse, and found all the learning was completed online via e-learning and that multiple modules had been completed over a very short period of time with no meaningful checks of competency.
- There was a distinct lack of qualified nursing staff with the relevant professional training, skills, and experience to effectively deliver nursing care to people living with complex advanced dementia. We saw no

meaningful evidence of continuous professional development or clinical upskilling being provided.
● The provider had failed to adequately train and support staff to use the electronic care planning system. Comments included, "I've no idea really how to use these things. The mobiles are a nuisance and just get in the way" and, "We were all sat around the telly and made to watch a video presentation. That was the total sum of our training for the care plans."

The provider had failed to ensure adequate support, training, and professional development, and where appropriate, failed to support staff to obtain further qualifications appropriate to the work they perform. This was a further breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The service was not always working within the principles of the MCA
● We reviewed a sample of records for people who were subject to DoLS and saw the appropriate legal authorisations were place. However, due to inconsistences in the way information was recorded in people's electronic care records, it was not always possible to ascertain if any associated conditions were being met.
● Capacity assessments completed by nursing staff were not always in line with the MCA. For example, a person had been deemed to have mental capacity to make decisions and staff had completed a mental health capacity assessment. However, upon checking the assessment we found there was a notable lack of recording for decision making in relation to this person's ability to weigh up the risk and benefits centred around the 'choices' they were making. This was exacerbated by the fact nursing staff told us they considered this person to have greater mental support needs than first thought on admission into the home.

● Blanket restrictive practices had been imposed on people by placing most beds at the lowest setting close to the floor. This action had been taken irrespective of whether a person was deemed at risk of falling out of bed or not.
● We saw the direct impact of this when we went to speak with a person who had been resting on their bed. Despite not having any major mobility issues, they were unable to get up from the bed independently and required our assistance. This person commented it was a 'daily occurrence' that they needed to ask for help, which they felt would be unnecessary if the bed had been at its regular height. For other people, there was an increased risk of injury should they attempt to go from a standing position down to their floor-level bed.

The provider had failed to follow the principles of the MCA and failed to properly assess people's needs and choices. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● The environment, décor and design of Peel and Kay units were not in keeping with national best practice guidance for supporting people living with dementia. For example, there was a distinct lack of appropriate wayfinding signage, and colour schemes were dull and dark.

● The registered manager had previously completed multiple environmental audits using a template from a reputable source and had shared these with the provider. However, the provider had failed to implement the necessary environmental improvements.

● People were prevented from accessing the communal garden because fencing panels were missing with an adjacent private property. This issue had been known to the provider for months, but no action had been taken. Staff told us they strongly believed this had resulted in an increase in distressed behaviours and agitation because people were 'stuck inside', especially during the recent warm weather.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care

● Communication between staff and primary care services was poor. Explanations regarding this were mixed, but staff described that some visiting healthcare professionals would frequently not provide any verbal feedback or document their findings before leaving the home.

● In contrast, primary healthcare professionals told us they often did not have confidence in reporting their findings verbally to staff, therefore would send written information separately, for example, via email. This whole issue was compounded by the fact visiting healthcare professionals had no formal means of accessing the providers electronic care planning system and therefore relied on staff to input details separately.

● Some people had previously missed their routine hospital appointments because local taxi firms had terminated their contracts with the provider for non-payment of invoices. This issue had been raised with CQC by several relatives ahead of our inspection. During the inspection, the registered manager confirmed to us this issue had now been resolved.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting and promoting people's privacy, dignity and independence

- Whilst it was evident some staff were caring and well intentioned, for others, they appeared indifferent and disinterested. Too often we observed staff not paying attention to basic matters of dignity, privacy and compassion.
- On Peel unit and Kay unit we observed some people walking around bare footed. On multiple occasions members of the inspection team needed to prompt staff to ensure people were wearing appropriate footwear.
- On Kay unit, after a lunch time service, we observed one person walking around wearing a jumper heavily soiled with dried food; this person had also clearly been doubly incontinent. It was obvious to us this person had been moving around in sight of staff, but staff failed to act. The unit manager eventually intervened and directed staff to attend to this person's personal care needs.

The provider had failed to ensure people using the service were treated with respect and dignity at all times. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care; respecting equality and diversity

- In the Effective section of this report, we detailed how the religious needs of 1 person had been disregarded. We looked in detail at other areas of equality, diversity, inclusion and human rights.
- We found the individuality and diversity of people receiving care and support was simply not acknowledged or celebrated in any meaningful way. This was particularly concerning for those people who may have protected characteristics. For example, characteristics based on race, sexual orientation, age, sex, or disability. This meant people were placed at an increased risk of receiving care and support that was discriminatory.
- We found no meaningful evidence that people, or their lawful representatives, had been provided with proper opportunities to be involved in decisions about their ongoing care. For example, some people had been required to move into Burrswood during the COVID-19 pandemic which meant they could not be offered another choice of care home at that time.
- However, some people, particularly those who were not originally from the Bury area, told us now restrictions had been lifted, they would have liked to explore alternative options with a view to be closer to family and friends. However, at no point had any such discussions taken place.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- As previously mentioned in this report, staff had not been properly trained to use the electronic care planning system. Staff did not yet always understand the functionality and benefits of the system. This meant assessments of people's care and treatment, including health, personal care, and ongoing reviews could not be planned in a person-centred way and information could not always be relied upon.
- The provision of activities and opportunities for people to follow their interests was woefully inadequate. The limited activities that took place were mainly concentrated on Crompton unit.
- There was too much of an inward focus and links with the local community were virtually non-existent.

The provider failed to ensure care and support was delivered in a person-centred way. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Given the issues already highlighted around definiens in the care planning and records, we could not be assured the provider was their obligations around the accessible information standard.

Improving care quality in response to complaints or concerns

- The provider had a framework in place which existed to support people to raise concerns and complaints. However, people consistently told us they were unhappy with the way their complaints had been managed. Comments included, "I raised a complaint with the manager but never got a formal reply", and "It feels like you're just paid lip service and senior managers don't really care."
- In contrast, people told us they had more confidence when raising concerns with unit managers. Comments included, "[Unit Manager] is very personable and friendly. Its much easier to speak with them as you know things will get done."
- In the reception area of the home, a 'you said we did' notice board was displayed. However, actions the provider claimed to have completed were inaccurate and clearly out of date.

End of life care and support

- People nearing the end of life were supported to remain in the home wherever possible.
- Relevant external healthcare professionals were also involved as-and-when appropriate.

Inadequate

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 has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Burrswood Care Home has consistently been rated less than Good since 2018. This included a rating of inadequate in 2021 when CQC took enforcement action. This is evidence of a history of failing to respond adequately to serious concerns raised by CQC and a failure to implement a culture of continuous learning.
- There were serious failings to safeguarding people at risk of abuse or neglect.
- When things went wrong, the provider, registered manager and others in key roles of responsibility within the home, had not been open, honest or transparent.
- There were significant failures in governance, audit, quality assurance and questioning of practice. Governance systems were not operated effectively and were not fit for purpose.

The provider failed to maintain good governance which placed people at an increased risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- At the time of this inspection the provider had embarked on a significant programme of change within Burrswood Care Home. This included closure of the general nursing unit and reallocation of roles which meant some staff faced redundancy. Other long-serving members of staff had already chosen to resign due to uncertainty about their future job security.
- People shared with us they considered a multitude of issues had been made worse by the providers inability to properly consult and communicate. People told us actions were imposed on them by the provider with no meaningful explanation why. Comments included, "I've always placed great faith in the unit managers and its devastating to learn they are being made redundant"; "It's unbelievable to think the owner is getting rid of staff when the home is experiencing such difficulties" and, "The whole place just feels like it's in a state of managed decline."

● There had been a systemic failure of leadership and management across all areas. There was a deep sense of mistrust between staff, the registered manager, deputy manager and senior managers acting for the provider. This led to a closed toxic culture amongst staff which led to poor quality care.