

U&I Care Limited

# Burton House

## Inspection report

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Date of inspection visit:  
07 February 2018

Date of publication:  
08 June 2018

## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Requires Improvement</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

This inspection took place on 7 February 2018. We requested additional information to be sent to us following the inspection which we received on 21 February 2018.

This inspection was unannounced. The inspection was conducted by an adult social care inspector.

At the last inspection of this service in 2015 the home was rated good. During this inspection breaches of legal requirements were found and home was rated 'Requires Improvement.'

Burton House is a care home for six adults that provides support and short breaks to young adults with autism/ learning disabilities and complex needs. Burton House is run by U&I Care Limited. It also provides day service support for a small number of people, which we do not regulate. The home is located in a residential area of Warrington. People staying at the home are supported by staff on a 24 hour basis. Each person has their own bedroom and shared communal areas. There are large well maintained gardens at the back of the house and parking at the front of the building.

Burton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of our inspection there were two people living at the home permanently, and four people accessing the short break services.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.' Registering the Right Support CQC policy.

A registered manager was 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 2008 and associated Regulations about how the service is run.

Staff recruitment checks highlighted that information was missing from a selection of files from staff who worked at Burton House. This did not demonstrate that robust recruitment checks were being undertaken by the provider when staff were starting working at the service. We checked the provider's policy with regards to the recruitment and selection of staff and found the provider was not always adhering to their own procedures.

Quality assurance systems were in place and reviewed on a regularly basis. We saw support plans contained

updates which had been hand written by staff if there was a change in support. The service had regular internal audits on service provisions as a whole which resulted in a red, amber, green (known as RAG) rating. Despite these audits taking place, some further improvements were needed to ensure the quality assurance procedure was effective as some issues we found in relation to best interests and staff recruitment had not been highlighted.

We saw that applications to deprive people of their liberties (DOLs) were being appropriately applied for. However, there was limited information with regards to decision making in general. Additionally, there was conflicting information within support plans with reference to what decisions people could make, and what required best interest involvement. We could not see any documented evidence of best interest involvement within the support plans viewed as the records were unclear. We have made a recommendation about this.

Medications were stored and administered safely by staff who had been trained to do so. Medication was clearly signed in and out by staff and the person's family member if they were only at the home for a short stay period. There was no plan in place for how to give medication which is needed as and when required (PRN) medication. We have made a recommendation regarding this.

Incidents and accidents did not always evidence that remedial action had been taken and followed up by the registered manager. We could not be sure what steps had been taken to prevent future reoccurrences. We have made a recommendation with regards to this.

Staff spoken with were able to explain the correct procedure for reporting actual or potential abuse. Staff had been trained in safeguarding adults, although more training was in the process of being implemented. There was a safeguarding adults policy and procedure and a whistleblowing policy in place at the service.

Risk assessments contained sufficient detail to enable staff to keep people safe from harm. Risk assessments were reviewed regularly by the staff, and any changes were incorporated into people's support plans. Consideration was given within the content of the risk assessments to people's diverse needs and behaviours.

We saw there were enough staff at the home on the day of inspection to ensure that people were supported with their assessed needs. There were different levels of support required for some people, and other people had one to one activity plans. We checked the numbers of staff against the activity planner and saw that each person was receiving the correct level of support.

The home was clean and tidy. Cleaning products were safely stored securely, and there was hand washing facilities available in the home.

We spoke to the house manager about the opportunities for lessons learned and how they have demonstrated this in the home, as we wanted to be sure the service was using opportunities to learn from their own practice to improve outcomes for people. We were given an example of this.

Staff were trained in a range of subjects and had received an induction prior to them commencing work at the home. We spoke to the registered manager at length regarding the training provided regarding autism awareness. Due to the complexities of some of the people at Burton House the autism training offered to staff was not as thorough as expected. The registered manager was looking at introducing new more robust training.

People at Burton House were well supported with their food and fluid intake. We saw most people were

supported to make their own meals and snacks, which they did as part of their planned activities.

People had access the GP and out of hours services if they were unwell.

The home was furnished to a good standard. There were accessible 'quite areas' for people to use in line with their needs to enable them to have their own space.

We observed positive interactions between people who used the service and the staff. Staff demonstrated through our conversations with them and by us observing them supporting people that they knew people very well.

Our conversations with family members and people at the home who were able to talk with us, confirmed that staff were caring and kind in their approach. Support plans were not always signed by people or their families, however some were signed and family members confirmed they had been involved in their relatives support plan.

There had been no formal complaints at the home, however we reviewed the organisations complaints process. People we spoke with confirmed they knew how to make a complaint.

People's support plans were respectfully written and there was an appropriate amount of depth and person centred information within each one we viewed. Consideration was given to people's background, routines and behaviours and these were all incorporated and strategized within their support plans.

Staff were trained and had some knowledge of end of life care. The registered manager assured us that more training would be incorporated into the staff training programme to ensure that all staff had a awareness of end of life care, and people's choices regards to this.

All of the staff, family members, and people who lived at the home we spoke with spoke positively about the registered manager.

Our conversations with the registered manger showed they were clearly passionate about providing good support and outcomes for people, and this was evidenced in some of the support plans we viewed. The registered manager was present during our inspection.

The rating for the last inspection was clearly displayed in the communal areas of the home and on the providers website.

## 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 always safe.

The service was not always completing robust checks on staff before they commenced work at Burton House.

Medication was stored and administered safely, however, people did not have separate plans in place for medication which was needed as and when required. We have made a recommendation about this.

Incidents and accidents were being documented and analysed for patterns and trends. Some incident forms did not include additional action which had been taken by the registered manager.

There was enough staff at the home to ensure people had access to their own activities and daily plans.

Risk assessments were informative, and presented in a way which helped mitigate risk whilst upholding the persons choice and diverse needs.

**Requires Improvement** 

### Is the service effective?

The service was not always Effective.

The service was not always working in accordance with the principles of the Mental Capacity act.

Training was in place for staff, and up to date. Staff confirmed they enjoyed the training.

People were supported with their food and fluid needs.

**Requires Improvement** 

### Is the service caring?

The service was Caring.

Staff spoke and treated people with respect and kindness.

People and family members spoke positively about the staff.

**Good** 

Staff described how they protected people's dignity and respected their wishes.

### Is the service responsive?

**Good** ●

The service was responsive.

People received care and support which was personalised to suit their needs.

There was no formal complaints for us to track, however people told us they were aware of the complaints procedure.

People engaged in activities which were meaningful and they were encouraged to be independent while completing tasks.

### Is the service well-led?

**Requires Improvement** ●

The service was not always Well-Led

Quality assurance procedures were in place which checked service provision, however, they had not highlighted some of the concerns we found during our inspection. We have made a recommendation regarding this.

Everyone spoke positively regarding the registered manager, and said they would recommend the service to others.

The rating for the home was displayed in the home.

# Burton House

## **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 7 February 2018 and was unannounced.

The inspection activity started on 7 February 2018 and ended on 21 February 2018. The provider sent us some information after the inspection took place at our request. Before our inspection we reviewed some of the information we held about the home, which included any notifications sent to us from the provider, and information from the local authority which helped us complete our inspection plan. We also viewed the PIR for the service.

During our inspection, we spoke with two people who used the service, two relatives of people who used the service and seven staff including the registered manager, house manager, and behaviour support manager. We looked at the support plans and associated documentation for three people. In addition we looked at a selection of recruitment files for staff who worked at the home and other locations across the organisation.

# Is the service safe?

## Our findings

During our inspection we looked at a selection of files relating to staff recruitment. We checked these files at the head office address of the provider, as staff work across different locations. In this instance, some of the staff who worked at Burton House also provide support to another location which is registered separately, but under the same legal entity of U&I Care Ltd.

We saw that not all recruitment files contained the correct information. For example, one reference was dated as being obtained after the staff member had starting working for the provider. Additionally, some people only had one reference in their files. We checked the organisation's recruitment policy and this stated that applicants needed to have two references. Also some information was missing from some files, such as no employment history, no education details and no details of referee contacts. Recruitment files contained no information around staff medical fitness for work, again which was a requirement according to the providers own policy and procedure. We saw that one person's DBS was not clear. A valid DBS check is a check for all staff employed to care and support people within health and social care settings. This enables the manager to assess their suitability for working with vulnerable adults. There was no further explanation or evidence that any risk assessment had taken place as a result of the DBS not being clear. We saw that one person had attended their interview for the organisation and yet the application form was submitted two months prior to this date. This shows that the provider was not following a safe and consistent approach with regards to the recruitment of staff, or following their own policy and procedure in relation to recruitment.

This is a breach of Regulation 19 of the Health and social care act 2008 (Regulated Activities) Regulations 2014.

The provider has since emailed us with a list of actions they plan to take to address these concerns.

We checked the procedure for managing medications within the home. Medication was stored in a locked cupboard within a locked trolley. The temperature of the room was recorded. Storing medications at the correct temperature is important because their ability to work effectively may be compromised. The temperature was being recorded twice daily. We asked if the service was currently administering any controlled drugs (CD)s. These are medication with additional safeguards on them. The service did not have anyone there at present who required controlled drugs.

We checked the Medication Administration Records (MAR)s for three people and saw that they were completed accurately and in full. The majority of people's medications were blister packaged, however we spot checked some loose boxed medication and saw the totals corresponded to what was recorded on the MAR.

We asked about medication which needed to be given as and when required (PRN). We saw that one person was prescribed PRN medication to take when they were in pain or discomfort. There was no separate PRN plan in place to explain when the PRN needed to be given, how often and how the person might



communicate that they needed PRN if they were non verbal. Not having a PRN plan in place could mean that newer staff who may not be familiar with the person yet might not realise they needed to offer PRN. So the person might not get the medication when they needed it.

We recommend that they provider reviews their approach to PRN medication and takes action accordingly.

We looked at how incidents and accidents were managed at the home. We saw that there was a process in place to analyse the number of incidents which occurred each month. There was also consideration given to how, when and why the incident occurred. Most of the incidents had been appropriately recorded in the incident tracker. However, there was no remedial action documented by the registered manager to say that the incident had been reviewed and that action was being taken. For example, we saw two incident forms for one person who had been verbally and physically aggressive at the home and out in public. When we reviewed this person's support plan, there was no indication at all that his person could display these behaviours. There was also nothing documented in the review section of the support plan. This meant that we were unsure if any remedial action had been taken as a result of these incidents. When we discussed this with the house manager they assured us that that information had been added to a new support plan which was in the process of being typed up. However, we did not see this. So we could not be sure action had been taken. The house manager acknowledged this and took action to rectify the information in the support plan.

We recommend the provider reviews their process for managing incidents and accidents and takes action accordingly.

People told us they felt safe at the home. One person said, "It's great, no concerns". Another person just said 'yes' when we asked them if they felt safe. We spoke to two family members of people accessing Burton House for short breaks. The family members we spoke with said, "I'm happy with the support here, I am actually very impressed." Also, "It is absolutely amazing. I know that [relatives name] can be quite complex, they [staff] do a great job." Also, "I never have to worry that they are safe."

Risk assessments were highly detailed and contained information around how to keep the person safe from harm, whilst ensuring their rights and choices were protected. For example, one person's support plan indicated that the person was at risk of choking. We saw their choking risk assessment contained specific control measures such as 'remain with me', 'allow my food to cool' and 'please be mindful I may store some food in my mouth'. There was also a detailed procedure which linked into the organisations first aid training of what to do if the person started to choke while waiting for the emergency services.

A risk assessment to support someone out in the community was available. Consideration was given to the person's dignity as the content of the risk assessment read, 'please remind me to use the toilet before we go out.' Additionally, we saw that staff were to take a spare set of clothes out for the person just in case they needed them, as this was reassuring for the person.

Risk assessments were in place which explored how one person's autism effected their daily life. The risk assessment was in relation to supporting the person in the community and how this can sometime be hazardous for the person and the staff. This was because the person's autism prevented them from 'moving on' which meant that they needed specific support to know what to do next. For example the person would stop in the street and refuse to move, which could cause injury. This risk was managed by staff being instructed to use specific words, phrases and interventions, again which linked in to their training. These examples show that the service is assessing risks individually for each person and providing remedial action for the staff to take which is focussed on the person's needs and choices.

Staff were able to describe the course of action they would take if they felt someone was being harmed or abused. This included reporting the suspected abuse to the registered manager, the local authority or contacting the police, depending on the nature of the concern. Staff had been trained in safeguarding adults and understood the different levels of abuse and who might be most at risk. There was also a whistleblowing policy in place. The staff knew what whistleblowing was and said they would report concerns without delay. We were informed that additional training was being rolled out to staff to further improve their knowledge of safeguarding procedures.

Our observations on the day of inspection at Burton House showed that there was enough staff available to meet people's needs and support them attending their chosen activity. We were informed by the registered manager that staff occasionally worked at multiple locations for the provider. Staff recruitment was on-going for the service. Rotas showed that there were a large number of staff used at Burton House, however, they all worked for U&I Care Ltd.

We spoke to the house manager about any areas where they have had to improve service provision. We wanted to be sure that the opportunity for lessons learned was being implemented at the home. The house manager described a recent change they have put into place regarding checking food storage items. This was due to scoring amber on the recent quality assurance check. This evidenced that the management were making positive changes within the home to ensure they were compliant with their own quality assurance systems.

We saw that all firefighting equipment had been checked and new equipment was in place in various parts of the home to help people evacuate safely. Personal emergency evacuation plans (PEEP's) explained each person's level of dependency and what support they would require to ensure they were evacuated safely. We spot checked some of the other certificates for PAT (portable appliance testing), electric, gas, and checks on the other equipment. These were all in date. We saw that fire doors were in working order.

We checked the process for preventing the spread of infection in the home. The home was odour free, clean and there were provisions for hand washing. Staff wore personal protective clothing (PPE) when supporting people with personal care.

## Is the service effective?

### Our findings

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 make 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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service was working within the principles of the MCA. Additionally, we checked to see whether the conditions identified in the authorisations to deprive a person of their liberty were being met. The registered manager was knowledgeable about the MCA and DoLS and knew that CQC (Care Quality Commission) needed to be notified when the outcome of any applications were known. We saw that two people who lived at Burton House permanently had a DoLS in place. One person's DoLS was subject to conditions. We checked these conditions as part of our inspection. There was no formal process in place by the provider which evidenced that the conditions of the DoLS were being adhered to. However, we saw within the support plan staff were adhering to these conditions.

Our examination of support plans evidenced a lack of information recorded around the documentation of best interests meetings. There was some detailed information for people around what decisions they could make for themselves, however some of this was contradictory throughout the support plan. For example, most people had information in place within their support plan which described what decisions they could make independently, such as what they wore or ate, and what decisions they needed help with. We saw on two occasions, it was documented that people could make decisions relating to clothing and food items independently with no help from staff. However, further inspection of their support plan indicated that the person could not always make these decisions and staff would be required to intervene. This involved discouraging the person from choosing unhealthy foods often or wearing non weather permitting clothing. This meant that information regarding how people made decisions and what support was needed from staff was not always clear.

Additionally, some people communicated using different forms of communication such as PECs or easy read information. However, no consideration was given to this type of communication within the person's capacity assessments. For example, one capacity assessment we viewed in particular was not accurate with regards to the how the person presented and communicated. The capacity assessment stated that the person 'is able to communicate their day to day decisions' however, the person was non verbal. They communicated mostly using sounds and gestures, which was not mentioned in the capacity assessment. Yet within another section of their support plan, it stated they were non verbal. This meant that although some decisions and choices were documented the records regarding capacity and consent were not always accurate or consistent throughout the support plans we viewed.

We recommend the provider reviews their approach to the Mental Capacity Act and takes action

accordingly.

The provider has since updated us via email to inform us that they have started to take action to change their approach to decision making and best interests. This included more training for staff around this.

Family members spoken with told us they felt staff were skilled. One family member said, "They are definitely good at their jobs, I never have to worry." Another family member said, "Oh yes, very skilled", when we asked about the staff.

We saw that people were assessed prior to them accessing the home. The initial assessment process focused on people's needs and choices while taking into account the support they required. We saw that this was different for each person depending on what their individual needs were. Family members spoken with confirmed that they were visited in their home before their relative attended Burton House to talk about their individual support needs.

We viewed the training matrix in place for staff. We randomly selected staff members and courses they were recorded as having attended. For all of the staff we checked we saw there was corresponding certification provided and all were accurate. This meant we were assured staff training was in date and accurate. Staff spoken with told us they felt the training was good quality and prepared them for skills they needed to support people.

We asked about specific training to support people with autism. This included a training programme solely based around reducing the need for restrictive practices for people with autism, (PROACT-SCIPr-UK®). There was no other autism based training, other than an induction to autism course facilitated by the registered manager. We spoke with the registered manager regarding accessing more specific and in depth training, due to the complexities of the people that were being supported at Burton House.

As part of their induction, staff were required to spend a week at head office to undertake training. The induction consisted of an induction to the company, and then a separate induction was undertaken by staff depending on which location they worked at. Training such as medication was completed online in the first instance, then staff were required to undergo a competency assessment to check they were able to give medication safely. They were required to refresh this training every 12 months.

Some staff had been enrolled on vocational qualifications such as NVQ's by an external company.

People were supported with their food and fluid needs. In some instances, we saw that consideration was given to people who required specialist diets, such as halal meat and low fat diets. During our inspection we observed people being supported by staff to make their own meals and snacks.

People were supported to access medical care when they required it. Each person had a health record in their support plans detailing their last appointments with GP's, opticians and chiropodists.

The home was decorated to a good standard. There were accessible 'quiet areas' for people to use if they required their own personal space. Some people were making use of these areas during our inspection.

## Is the service caring?

### Our findings

People we spoke with and family members spoke positively about the home and the staff. Comments from one relative included, "The staff are absolutely excellent, I just couldn't ask for better." Another relative we spoke with said, "They are very good. They know [relative] well." Also "They [staff] are always so friendly and helpful, its like nothing is too much trouble." One person who was accessing the service at the time of our inspection also told us they liked the staff.

We observed kind, caring, familiar and warm interactions throughout the duration of our inspection. We observed staff supporting people to get ready for their planned activities. Staff were encouraging people to look at their planners and describe what they were doing that day.

We observed one person being supported by staff to make their lunch. The staff member asked us if we could give the person space to do this, as they would not appreciate our presence in the kitchen area. We saw from looking at this person's support plan that this was a strategy in place to help them manage their behaviours whilst cooking food. This meant that the staff member was familiar with the person's needs and preferences and made sure they had a safe environment to complete their task.

Staff described how they provided dignified support to people. One staff member said, "Its so it's important to be respectful and ask permission as you would anywhere." Another staff member said, "We appreciate people are all different, and we have to treat them as individuals."

Support plans demonstrated that family members and people using the service had been fully involved in their completion and had been involved in regular reviews about their care and support. Family members we spoke with also confirmed they had been involved in any changes to care needs. We saw examples in support plans where a change had been incorporated. It clearly stated that the person's family had been involved in the change. Some support plans had been signed by family members where legally allowed to do so.

We spoke about assessable information and saw that people's support plans or policies were not presented in any additional format for people who may require it. This meant that unless people could read, write or had capacity to understand their support plan, their involvement was limited. We spoke to the registered manager who informed us they would be implementing some documentation which would be more accessible for peoples needs.

## Is the service responsive?

### Our findings

Family members spoken with told us that they felt the staff were responsive to their relatives needs and knew and understood them well. Comments included, "They [staff] are spot on with knowing what [family member] likes and "They all have such a good understanding of [family member] they enjoy being there [at Burton House]."

We spent time looking at how people received care which was person centred. Person centred means care which is based around the needs of the person and not the company. We saw that detailed information was recorded in people's support plans regarding their likes, dislikes, routines and communication needs. For example, one person who was unable to verbally communicate, had a communication plan in place which had been completed by staff. The plan described what gestures or signals the person used and what the staff thought they meant. We saw this had been reviewed and complied over a period of time, and was now a useful document with regards to providing the right support to the person. This meant that newer staff would be able to understand how to communicate with them.

Information in support plans was respectfully written and encouraged people's independence as much as possible. For example, one person's support plans stated, 'do not do the task for me, unless you feel I am struggling'. Additionally, there was information for staff with regards to how to verbally support this person without using words or phrases which might trigger their behaviour. This was documented in the support plan as 'staff don't say..... try to say.....instead'. This meant that staff had clear guidance in place of how to support the person verbally, which could mean there would be fewer incidents of people challenging the service.

We observed that one person was becoming agitated. We saw the staff take the person out for a walk to engage in an activity, and when they returned they sat in the 'snug' area in the garden to eat their lunch. When we read this person's support plan, we saw that this was a preferred method for the person to eat their lunch when there were strangers in the house. This meant that person was calm and relaxed whilst eating their lunch.

There was information around people's routines and personal care preferences. This was clearly documented in a step by step process of how the staff needed to support the person with these tasks. We did not, however, see any preferences noted in support plans for preferred gender of support worker or any skill matching of staff. It was not documented anywhere in the support plans that this had been considered. Relatives, however, did feed back they liked all of the staff who worked at Burton House.

People had full and varied recreational activity planners which encouraged their participation in the community. During our inspection most of the people who were accessing Burton House were out on their chosen activities with their staff members. Each person's activity planner had a picture of the staff member who was supporting them that day, and a photograph of the activity they would be engaging in. We saw that one person had been shopping, then they came home, made pizza for tea, and attended a disco in the evening. Family members spoken with told us that their relative had access to the community and felt they

were getting the best out of their support.

We looked at how complaints were managed in the service. There had not been any formal complaints about Burton House since our last inspection. Family members spoken with told us they would know who to approach if they wished to complain and that the complaints procedure was discussed with them before using the service. The complaints procedure was displayed in the home. We raised during our inspection that the complaints procedure was not presented in any additional formats which might suit people's needs such as easy read, or audio. The registered manager said they would look at making the complaints procedure more accessible for people.

We looked at how the end of life was managed in the home. We saw that there was some training and awareness into providing support for people regarding accessing end of life services. However, most people in Burton House did not need this type of support.

## Is the service well-led?

### Our findings

We saw during our inspection that there was a system in place to monitor the provision of the service. This was aligned to CQC's own domains of Safe, Effective, Caring, Responsive and Well-led. The documents operated on a red, amber green (RAG) rating. Every month a senior manager would audit the service to ensure they were compliant. We saw on one recent audit, the service had been given an amber rating under 'safe' due to more checks being needed on the food provisions. We saw that an action plan had been completed and put into place by the house manager. In addition, support plans for people were reviewed every month, and any changes were incorporated into the support plan. Following this a new support plan was generated by head office. There were also checks being undertaken on the safety of the building, and the fire alarms. We highlighted however, that despite some of these checks taking place, the current quality assurance systems had failed to identify some of the issues we found in relation to staff recruitment, mental capacity, families not always signing care plans and the management of incidents and accidents. In addition, the records we viewed in relation to mental capacity and best interests were not consistent throughout the support plan. This meant that these records were unclear and although some of the quality assurance systems were clearly effective, further improvements were needed.

This is a breach of Regulation 17 of the Health and social care act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with was complementary regarding the registered manager and the house manager. Comments included, "[Registered manager's name] is really nice, I felt very assured." Also "[House managers name] is really lovely, nothing is too much trouble." The family members we spoke with said they would recommend the service to others.

The registered manager and the house manager were available during our inspection and made a range of documentation available to us. We later requested some more information to be sent via email, which we received.

Our observations and discussions with staff evidenced that the home was friendly, caring and very much tailored around the people who were accessing the services of Burton House at the time. Our conversations with the registered manager indicated that they led by example, and they were well known in Burton House by the people who were there.

All of the staff spoken with said they liked working for U&I Care Ltd and enjoyed their time at Burton House.

Team meetings took place every month and we were able to see minutes of these. The communication with people who use their service and their families was on-going. We saw handwritten notes in people's support plans when information had been shared or families had been contacted.

Peoples personal information was stored securely in lockable cabinets.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating.



'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Burton House was displayed in the main part of the building, and the provider's webpage. Notifications had been reported to the Care Quality Commission.

Our discussions with the registered manager assured us they fully understood what they needed to report to us by law.

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	Regulation 17 HSCA RA Regulations 2014 Good governance  Audits did not always highlight some of the inconsistencies within service provision.

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Staff recruitment procedures were not robust and information was missing from some staff recruitment files. The provider had not followed their own policies and procedures in relation to recruitment for some staff.</p>

### **The enforcement action we took:**

Warning Notice against provider.