Care UK Community Partnerships Ltd

The Burroughs

Inspection report

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Date of inspection visit:
27 February 2018

Date of publication:
17 April 2018

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

The inspection took place on 27 February 2018 and was unannounced.

The last inspection of the service took place on19 April 2016 when we rated the service Good in all key questions and overall.

At this inspection we have rated the service Requires Improvement in all key questions and overall.

The Burroughs is a 'care home'. People in care homes receive accommodation and 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. The service is registered to provide care for up to 75 older people in a single building. Accommodation is provided on two floors. The ground floor is for people living with the experience of dementia. The first floor accommodates older people who may or may not be living with the experience of dementia. The provider does not employ nursing staff. However, local community nurses work closely with the staff and have an office at the service from which they provide any nursing care which people need. At the time of our inspection there were 59 people living at the service.

The service is provided by Care UK Community Partnerships Ltd, part of Care UK, a national organisation providing health and social care.

The registered manager had left the service since the last inspection. There was no registered manager in post. The provider's representatives told us that they had recruited a manager who was due to start work at the service in July 2018 and that this person would apply to be registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider was not always acting in accordance with the Mental Capacity Act 2005 because the assessments of people's capacity were not always reflected in the way their care was planned. People had not always been asked to consent to their care and treatment and the staff did not always understand their responsibilities under the Act.

The provider's systems for identifying and mitigating the risks to people's safety were not effective because they had not always checked that the environment was safely maintained or that risks had been fully assessed and recorded. The systems and processes for monitoring and improving quality had not always been effective in achieving improvements.

We found two breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to consent to care and treatment and good governance . You can see what

action we told the provider to take at the back of the full version of the report.

The provider was not always meeting people's needs in a person centred way. For example, people's preferences in relation to personal care were not always being met. People were not always involved in reviewing how they were being cared for.

Some of the staff felt that improvements were needed in the way they worked effectively together as a team to deliver care to people because they felt communication needed to be improved and that not all staff were working the same way.

The provider had not employed a full time or permanent manager for the service. The registered manager of another similar sized home was working part time at both services and this meant that they did not always have enough time to embed the improvements which were needed.

People felt they were safe and well cared for. They liked living at the service and they had good relationships with the staff. The staff were kind and caring. They knew people well and wanted to meet their needs. Care was planned in a person centred way with enough information for the staff so they knew how to support people. People were asked their opinion about the service and felt able to raise concerns or make complaints.

The staff felt supported and had enough training and information to undertake their roles. There were enough staff on duty and they had been recruited in a suitable way.

There were procedures designed to keep people safe and protect them from abuse. People received their medicines in a safe way. The environment was clean and appropriately maintained. People had enough to eat and drink and they were supported to access healthcare services when needed.

The provider had systems for monitoring the quality of the service and identifying where improvements were needed. They undertook regular audits and there was evidence that they had taken action to make improvements when they found these were needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Some risks to people's wellbeing and safety had not been mitigated, although the provider gave us assurances that they would take action in respect of these risks.

There was not always evidence to show that staff had learnt from incidents to ensure these did not happen again. However, the provider had started to make improvements in this area following identifying deficits themselves.

There were procedures designed to safeguard people from abuse.

There were sufficient numbers of staff to support people to stay safe and meet their needs.

People received their medicines as prescribed and in a safe way.

There were systems designed to protect people by the prevention and control of infection.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Consent to care and treatment was not always sought in line with legislation and guidance.

People's needs and choices were assessed.

The staff had the skills, knowledge and experience needed to deliver effective care and treatment. However some staff raised concerns about the way in which they worked together and supported one another.

People's individual needs were met by the adaptation, design and decoration of the premises, although a lack of informative signage meant that some people found it difficult to orientate

themselves.

People were supported to access healthcare services when they needed.

People were supported to maintain a balanced diet and had enough to eat and drink.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Whilst interactions between staff and people showed kindness and compassion, people were not always enabled to make decisions about their care.

People's privacy was respected.

People were supported to maintain independence and to feel valued and supported in expressing their identity.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care was planned to meet their needs and reflect their preferences. However, they were not always consulted when care plans were reviewed to take account of changes in how they wished to be cared for.

The staff generally met people's assessed needs, but this was not always the case according to the records of care.

People's complaints and concerns were listened to and the provider responded appropriately to these.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

During the inspection we identified areas requiring improvement. These were also identified by the provider during their own quality monitoring.

There was no permanent manager at the service and the covering manager worked only part time because they were also managing another care home of a similar size. This had an

impact on how quickly and thoroughly improvements were being made.

The provider had effective systems for monitoring quality and identifying where improvements were needed. They had taken appropriate action to start making these improvements.

The provider consulted with people living at the service and other stakeholders.

The Burroughs

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 27 February 2018 and was unannounced.

The inspection team included three inspectors, a pharmacy inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report, notifications of significant events and safeguarding alerts and information we had received from stakeholders about the service. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We looked at a national care home review website to see feedback people had left about the service and the food standards rating website. We had received a fire officer report following their visit to the service in September 2016. We spoke with the local authority quality team who had undertaken visits to the service. They shared the most recent report of their findings and the provider's action plan which outlined improvements they were going to make.

The provider had completed a Provider Information Return (PIR) in January 2018. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 12 people who lived at the service and six visiting relatives and friends. We also met two visiting healthcare professionals. There was no manager in post at the time of our inspection, a registered manager from another service visited during the day to assist the staff with finding information for the inspection team. We also met the provider's operations support manager who was assisting with the management of the home, and staff on duty who included, administrative staff, care

workers, senior care workers, team leaders, domestic staff, catering staff and activities coordinators.

We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the whole care plans for six people and part of the care plans for nine other people, staff recruitment, training and support records for six members of staff and other records used by the provider for managing the service, which included meeting minutes, audits, quality checks, records of complaints, compliments and safeguarding alerts. The inspection included checks on the environment and equipment being used. The pharmacy inspector looked at how medicines were being managed which included looking at administration, storage, records, staff competency assessments and audits.

At the end of the visit we gave feedback to the registered manager from another service and the operations support manager. After the visit the regional director emailed us with information relating to our feedback.

Requires Improvement

Is the service safe?

Our findings

People using the service told us they felt safe. Some of their comments included, ''I feel safe'', ''It is always comfortable and all you have to do is ask if you need something'' and ''I trust the staff and feel safe here.'' One person told us that they had concerns that some food they had purchased had been taken from their room, they said they had reported this to the staff. We observed that bedroom doors were often left open and unsecured during our inspection when there was no occupant in the room. This increased the risk that someone may walk into the rooms and take something without permission. The provider had a procedure for recording valuables and had facilities for storing these safely but no specific procedures relating to checking that other items were not taken from unsecured rooms. Following receipt of the draft report the provider told us that they had a policy that bedroom doors would not be locked unless this was agreed by the person using the service or a best interest decision had been made regarding this.

The risks to people had not always been mitigated. During the inspection we found that two sluice rooms and one electrical meter cupboard were left unlocked. Some people living at the service experienced dementia and this may have impaired their ability to judge the risks associated with these rooms. In one of the sluice rooms there was an unlabelled plastic container with a clear liquid. We were told that this was water and not a cleaning product. We advised the visiting registered manager of our findings and they took action to secure the rooms and make sure all containers were appropriately labelled. The regional director advised us that daily audits were in place to ensure that these rooms would be secured in the future.

At one point during the inspection we observed a person was in bed with their call bell out of reach. We checked the person's care plan and saw that they were at risk of falling. There was no information about whether they had capacity to understand and use their call bell. We discussed this with the provider's representatives. The regional director agreed that they would review people's assessments to make sure information about capacity to use call bells was clear and that risk assessments relating to this were up to date.

The provider had procedures for safeguarding adults and whistle blowing. Information about abuse and how to report this was available on posters around the service and staff rooms. The staff had received annual training regarding safeguarding adults. The staff we spoke with were able to explain their responsibilities and how they would respond if they thought someone was being abused. The provider had worked closely with the local safeguarding authority and other agencies to protect people following allegations of abuse.

The staff undertook a range of risk assessments with included risks to people's health, skin integrity, nutrition, assisted moving, risks of falling, choking and equipment being used. The assessments were clearly recorded and included information about how to minimise harm and keep people safe. Risk assessments were reviewed and updated each month.

We observed people being supported to move around the home by staff. The staff assisting people did so carefully and considered people's safety and wellbeing. We also observed people being supported at

mealtimes. The staff made sure people were positioned appropriately and had the right texture of food and drink so that risks of choking were minimised.

The provider ensured that there were regular checks on health and safety, electrical safety, gas and water supplies and fire safety. There were procedures for evacuating people in event of an emergency, including individual evacuation plans for each person. The staff were aware of these and had regular fire safety training.

There were enough staff employed to keep people safe and meet their needs. People who we spoke with confirmed that staff were available if they needed them. They told us that call bells were answered quickly when they used these. The staff also felt there were enough of them. Some staff told us that there were times when more staff would be helpful but they felt people were safely cared for with the staffing levels.

We observed that people's needs were being met and they did not have to wait for care. The staff were available in communal rooms and offered assistance when people needed this. The staff appeared calm and did not rush people.

The staff wore uniforms and name badges so that people could identify who they were and their role.

There were appropriate procedures for the recruitment of staff. These included checks on their suitability such as, their identity and eligibility to work in the United Kingdom, references from previous employers, information about their employment history and checks with the Disclosure and Barring Service to see if people had a criminal record. Staff were invited for formal interviews and had to complete an induction and probationary period before they were confirmed in their role permanently. We saw evidence of these checks in the staff files we viewed.

People received their medicines in a safe way and as prescribed. There were procedures for the administration of medicines and the staff had training in these. The staff competency when administering medicines was assessed annually. We observed people being given medicines. The staff did this appropriately checking on the person's wellbeing and making sure they knew what was happening.

Medicines were stored securely and appropriately. The staff undertook checks on the temperature of storage areas each day.

Medicines administration records were completed accurately. Information was clearly recorded and there were checks to minimise the risks of people receiving the wrong medicines. The staff undertook daily audits of medicines records and amounts of medicines being held at the service.

There were appropriate procedures regarding the use of PRN (as required) medicines and clear information for the staff about how they should identify when people were in pain or needed PRN medicines. There were systems for receiving, managing and disposing of medicines. There was a procedure to be followed in event of someone being able to administer their own medicines and the staff were aware of these. This did not apply to anyone at the time of our inspection.

One person told us that they had concerns about the way in which the staff handled food they were serving. They explained that they had seen the staff using bare hands to touch food and sometimes ate food whilst they were serving. Other people told us they felt there were no concerns with cleanliness or control of infection. They told us the staff wore aprons and gloves when providing care or handling food. This was also our observation on the day of the inspection.

The staff had training in infection control and there was information on display about hand hygiene and cleanliness. We saw domestic staff were employed throughout the day to keep the service clean. They had schedules which they followed and the provider undertook audits relating to cleanliness and infection control.

Shortly before our inspection there was an incident at the service where an outbreak of an infectious disease affected a number of people. The provider responded appropriately to this taking action to control the spread of infection and to keep people safe.

The staff recorded all falls and accidents at the service. Information about these was shared with the local authority and provider. The staff recorded the action taken to care for the person following a fall and also action taken to reduce the risk of further falls, for example referral to specialist professionals, increased observation and assessment of equipment to support people. The provider's analysis of falls included investigating any trends or patterns to identify if changes to the service were needed.

In August 2017 a review by the local authority identified a gap in the analysis and review of incidents and accidents. The provider had also identified concerns during their own quality audit of the service in January 2018. We saw that action had been taken to rectify these concerns and make improvements to the way in which accidents and falls were reported and responded to.

Requires Improvement

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were not always doing so.

There was not always evidence that decisions about the administration of people's medicines had been made lawfully. Medicines administration records indicated that three people received their medicines covertly (without their knowledge and sometimes disguised in food or drink). The senior staff responsible for administering medicines told us that only two people received their medicines in this way and that the record of the third person had not been updated to show they no longer received medicines covertly. There was no additional information about this such as evidence of best interest decisions or a mental capacity assessment. The fact the medicines administration records still referred to covert administration meant the person was at risk of receiving their medicines in a way which was no longer appropriate for them and imposed restrictions on their freedom and right to refuse medicines.

According to the staff only two people were administered medicines covertly. We found evidence of a multidisciplinary agreement and mental capacity assessment in respect of one person, but not the other person. There was insufficient information about how the decision to administer the second person's medicines covertly had been made and therefore the person was at risk of receiving unlawful care and treatment. The regional director told us that they would review the information held in respect of people receiving medicines covertly and make sure that the decisions had been made in the person's best interest and were accurately recorded.

The provider had not always made sure the staff understood the principles of the MCA and therefore they may not have carried out their duties appropriately. Senior staff had completed mental capacity assessments in respect of people living at the service. When we spoke with these staff about their responsibilities under the MCA they were not able to tell us about any of the key principles of the MCA or why DoLS applications were necessary.

The information about people's mental capacity was not always consistently recorded and this meant they were at risk of unlawful care and treatment. Do Not Attempt Resuscitation (DNAR) agreements are used when a best interest decision has been made not to prolong a person's life by resuscitation in event of their heart stopping. People who had the mental capacity to understand this decision had the right to decide if they wanted a DNAR agreement or not. This was not always the case at the service. The care records for two people stated that they had capacity to make decisions. However, both people had a DNAR in place which had been agreed by others and there was no evidence they had been involved in the decision.

The provider had not always ensured that best interest decisions had been made when people lacked the mental capacity to make a decision. In one instance, a person's representative had signed a form refusing permission for photographs of their relative to be taken and used. The care records for this person included photographs. There was no additional evidence to explain whether this had been discussed with the person, or their representative and no evidence of a best interests decision in relation to whether photographs were needed to ensure the person received effective care and treatment. In another example we saw that consent for flu vaccinations had been signed for six people. The forms did not indicate who had signed or whether there had been a best interest decision in relation to people receiving the vaccination. There was no evidence of best interest decisions for other people who had received this vaccination.

The provider had not always recorded who had the legal authority to make decisions on behalf of people. The Lasting Power of Attorney is a legal tool whereby a representative of a person has the legal authority to make certain decisions on their behalf. The provider's care planning system had sections where information in relation to this could be recorded. We found that these had not always been consistently completed and in some cases the named person with authority within these differed from the named person on other documents, such as DNAR forms.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had made applications for DoLS authorisations for people who lacked capacity to make decisions about their care. DoLS authorisations are time limited and four people's authorisations had expired in 2016, five people's had expired in 2017 and one person's had expired in January 2018. The provider shared a document with us that showed that they had reapplied for these authorisations, but not until January 2018, meaning that some people were being restricted without proper authorisation.

People's needs were assessed in line with legislation and good practice guidance. The staff completed pre admission assessments with each person, asking them about their needs and specific likes. The provider had a system to ensure that assessments were completed within specific timeframes once someone moved to the service. For example, risks, personal evacuation plans and baseline observations had to be completed within hours of the person moving to the service, with assessments relating to less urgent needs being completed within a week of them moving to the service. We saw that people's personal preferences were recorded within their assessments which highlighted their strengths and needs. The assessments had been incorporated into care plans. They were regularly reviewed and updated. The assessments included nationally recognised tools for measuring people's needs in different areas, for example skin integrity, nutritional risks, risks of falling and health conditions. The staff used these to identify the level of risk and need for each person.

The staff had the skills, knowledge and experience needed to deliver effective care and treatment. New members of staff undertook a range of training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. The provider had systems to ensure that staff undertook regular training updates. The staff confirmed they received regular training to ensure their skills were current. This included training in moving and handling, safeguarding, infection control, health and safety, food hygiene and dementia.

The staff were familiar with individual needs, abilities and routines and were able to discuss different people's needs when asked, explaining their background, ways of communicating, needs and risks to their safety.

The staff took part in regular individual and team meetings with their line manager. They confirmed that these were useful and allowed them to discuss their work. Some staff felt they did not receive opportunities for promotion and career development. However, the provider's representatives explained that staff were given opportunities to apply for promotions and they were able to talk about examples where staff working at the service had been promoted to new roles. The staff told us they received appraisals of their work and we saw evidence of these.

The staff we spoke with were positive about working at the service and told us they liked their roles. They were able to explain the systems designed to communicate people's needs and deliver effective care. For example, there were daily handovers of information and systems for the staff to record changes in people's wellbeing. There were clear lines of delegation, with senior staff working alongside care workers to provider care and support to people. However, some staff raised concerns about the lack of a permanent manager at the service. They explained that three different managers had worked at the service in the past year, along with two different deputy managers. Some of the staff felt unsettled by this and commented that they had no one to discuss their concerns with regarding any issues they had with other staff. We saw that records of staff meetings at the service indicated some discontentment amongst the staff team with some members of staff feeling others did not work effectively. The regional director told us that they were already aware of the low morale of some staff and had worked with the manager overseeing the service to improve this and give the staff an opportunity to express any concerns they had.

The building was large and people told us that they sometimes found it difficult to orientate themselves. This was confirmed by staff who told us that when they started working at the service and when new people moved to the service they sometimes became lost. We discussed this with the provider's representatives who agreed to look at how they could improve signage and support better orientation for people.

The provider had taken steps to create interactive and attractive features throughout the communal areas. These included tactile or puzzle wall displays, sensory equipment and a range of pictures and themed rooms. The corridors were wide and included hand rails. Equipment was stored in suitable areas out of people's way. The communal rooms were light and well ventilated with different seating arrangements to meet people's needs. People had personalised their bedrooms with their own furniture and belongings. Equipment was safely maintained and subject to regular checks and servicing.

There were notice boards throughout the service which included information for people and their visitors, such as meeting minutes, information about making complaints, details about activities and information about dementia. People received a poster of planned activities to keep in their room each week. Menus were displayed on tables in the dining rooms so people knew the meal choices for each day.

People were supported to access healthcare services when they needed. The staff at the service worked closely with the local GPs and other healthcare professionals to make sure people's needs were being met. Community nurses visited the home each day and the GP visited weekly. The staff had assessed people's healthcare needs and recorded these in their care plans. There was evidence the staff monitored changes in people's health and reported these to external professionals. We saw that healthcare consultations were recorded and information from these had been incorporated into care plans. The relative of one person told us that they did not believe the staff monitored the health and wellbeing of their relative. However, other people told us that they were satisfied with the support they received in this respect. The two external healthcare professionals we spoke with told us they felt the staff had a good knowledge of people's healthcare needs and responded to changes in people's condition.

People were supported to maintain a balanced diet and had enough to eat and drink. People told us they

liked the food and the service. Their comments included, ''It's not too bad'', ''I love the food'', ''It is quite good and I eat it all up'', ''They cater for my specific needs'', ''Breakfast is nice'', ''It is very good'' and ''I like the food but I have to ask if I want snacks between meals.''

The staff offered drinks to people throughout the day and these were available for people to help themselves where they were able. The catering team prepared a range of choices for each meal and these were offered to people. Homemade cakes were offered in the afternoon and fruit, milkshakes and biscuits were available mid-morning. The catering team had a good understanding about people's special needs and dietary requirements. They had information about each person including their likes and dislikes, allergies and any healthcare needs. The chef spoke with people at the service about their enjoyment of the food and any feedback about changes they required.

There were effective systems to ensure the kitchen was clean and food was stored at the right temperatures and appropriately.

Requires Improvement

Is the service caring?

Our findings

People using the service told us that the staff were kind and caring. Some of their comments included, ''They treat me with dignity'', ''They are all lovely'', ''They chat to me and are all very nice people'', ''They always help you'', ''They will do anything to help'' and ''They are all perfect.''

We witnessed the staff being kind, compassionate and attentive towards people. They asked about people's wellbeing and spoke with them in a caring way. During the inspection we saw a number of occasions where people became distressed or needed reassurance. The staff provided this in a gentle and caring way.

Three of the people who we spoke with told us that they had been asked whether they wished for same gender care workers, although other people told us they had not been asked. Some people said that they thought they were not allowed to make a decision about this and they required clarification about this from the provider. We saw evidence that this had been discussed with some people and recorded in care plans. However, some people's care records did not include reference to this and therefore it was not clear whether people had been asked for their preferences.

We saw that in a few circumstances the service was not always caring. People's rights were not upheld and their dignity respected particularly around their rights to make decisions about their care or be involved in reviewing their care plans. For example people were given covert medicines and there was no evidence that due process was being followed.

People told us that their privacy was respected. We saw that staff spoke discretely about people's needs and offered support in a sensitive manner. They knocked on bedroom doors and addressed people by their preferred names, which were recorded in their care plans.

During the preadmission assessments, the staff had recorded people's known preferences in care plans. We saw the staff offering people choices and respecting their decisions. Although at times the care staff did not always initiate the right response to people expressing their choices and had to be guided by senior staff. For example, one person showed that they did not want to wear a protective apron. The member of care staff persisted in trying to place this on the person until they were told not to by a senior member of staff. In another example, a care worker told a person that they needed to move to a different room even though the person indicated they wanted to stay where they were. Again, a senior member of staff intervened reminding the care worker to respect the person's choice.

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People told us that they were invited to meetings where they were informed about the service and asked for their opinions about activities, decoration and menus.

People's cultural needs were respected and they were supported to practice their religion if they wished. Information about people's cultural background and religion was recorded in care plans. The manager who was overseeing the service had started an initiative to increase awareness of the LGBT+ (Lesbian, Gay, Bisexual and Transgender) community. They had found that some people had experienced prejudice and

felt they had to hide their identity. In order to create a better understanding and empower people they had started an initiative to look at different ways for the staff to ask people about their lives and help them to feel safe expressing their identity. They were promoting this by improving information for people living and working at the service and celebrating LGBT+ awareness month.

People were supported to maintain independence where they were able to. Care plans explained about people's strengths and the tasks they could do for themselves. We saw that people used special equipment to maintain independence, for example using specially designed plates and cups so they could eat and drink without assistance.

Requires Improvement

Is the service responsive?

Our findings

People's preferences and wishes were recorded in their care plans, however information received by the provider through satisfaction surveys and audits indicated that people were not regularly involved in reviewing their own care. The provider had a system of ''resident of the day'' which was designed to enable a holistic review of care involving the person each month. In a sample of records we viewed we saw that the majority of people had not had such a review for over a year. The provider had identified this issue themselves and had made plans to improve this. They had written to all relatives and other representatives informing them when the monthly review for each person would be so that could be part of this if they wished. However, the reviews had not yet taken place and people living at the home were not aware when their review date was, nor did they feel involved in this process.

Record which showed when people had been supported to have baths and showers were not always clear. We saw one person's care plan stated that they liked a daily bath; however we found no evidence to indicate they had received support with this. In another instance a member of staff told us they knew a person liked to have daily showers, again there was no record to show that they had been offered these.

Care plans included detailed information about people's needs and how the staff should meet these. The care plans we viewed were personalised and included information about people's preferences, strengths and abilities. The staff reviewed care plans each month and changes in need had been recorded. The staff also completed records of care delivered and these showed that most of the time care plans were being followed.

The staff had started to work with people and their families to create ''my life story'' books which explained a bit about who the person was and what was important to them. The staff we spoke with knew about individual people's preferences and information about their lives before they moved to the home.

Rooms had "This is Me" posters displayed on the wall giving information such as what their preferred name is, please be aware of the following about me…, I am allergic to …etc."
In each room, there was also a "My Life Story" book.

The provider employed activity coordinators who planned and facilitated social activities. These were advertised on posters which were given to each person. Regular group activities included exercise groups, visiting entertainers, reminiscence sessions, craft activities and games. There were some organised trips out of the home. However, we spoke with two people who commented that they would like more opportunities to get out of the home and to access the local community. One person said that they had been promised more support in this area but this had not happened.

During our observations we saw that some people were engaged in group social activities and some spent time with visitors or pursuing an individual interest. We also saw that some people did not engage in activities and that they did not receive attention from the staff except to meet a specific need, for example at mealtimes.

The manager overseeing the running of the service at the time of the inspection had introduced 'a wish tree', an initiative they had used elsewhere. This was designed to enable people to make requests for a personalised activity and support them to fulfil these. This was in the early stages at the time of the inspection but one member of staff told us they hoped to support a person to attend a football match, which was a particular request they had made.

People told us they knew how to make a complaint. There was information about the complaints procedure displayed around the service. The provider kept a record of all complaints and concerns received and how these were responded to.

No one living at the service at the time of the inspection was being cared for at the end of their lives. However, care plans included a section where people's wishes for care during this time were recorded so that they could receive the right care and support when needed.

Requires Improvement

Is the service well-led?

Our findings

People told us that they liked the service and thought that it was well-run. Some of their comments included, ''So far, so good, there are friendly people you can joke with'', ''They are very helpful and they help me the best they can'', ''It is a good service'', ''I love it here''. ''The staff and the people are the best thing'', ''It is very homely and all the staff are nice'', ''They are lovely here, the girls really look after [people]'' and ''I like living here.''

A website used for reviewing care homes included one review made in 2018 and one in 2017 giving the home an average rating of 7.5/10. One review had included the comment, ''Total care, trust and empathy is given to the residents, family and visitors. The staff are always ready to give information about the residents, always filling the family in if there are any problems, illnesses etc. We are informed about medication and problems with [person's] needs. I have spent Christmas with [person] in the home, it was a great day with good food and great staff. I cannot fault anything with The Burroughs in terms of care standards and well-being for [person].'' The other review stated, ''The home is run very well and clean at all times. Staff are very helpful making time to talk to [person] and myself.''

The provider did not always operate effective systems to identify and mitigate risks. During the inspection we found that two sluice rooms and an electric meter cupboard had been left unlocked and there was a risk that people could access these. Furthermore the provider had not completed assessments of risk relating for one person who did not have access to their call bell. The provider's own monitoring had not identified these risks.

The provider was not always operating effective systems to assess, monitor and improve the quality of the service. We found a breach of Regulations relating to consent to care and treatment. Our findings indicated that people's needs were not always being met in the way they wished or in their best interests. For example, the provider was not always acting in accordance with the Mental Capacity Act 2005 and care was not always provided in a way which reflected their preferences. The provider had identified that people using the service were not been actively involved in reviewing their care, however action to make improvements had not been effective at the time of the inspection.

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

In March 2017 the registered manager who had worked at the service for a number of years left. A new registered manager was employed from July to November 2017. At the time of the inspection there was no permanent manager in post. The registered manager from another Care UK care home was spending part of their time managing The Burroughs. This arrangement provided some stability and support for the staff, however it was not sufficient for overseeing the management of a care home of this size and complexity. The staff felt supported by the covering manager but also spoke with us about their concerns regarding the day to day running of the home. In addition, the provider's own monitoring and our findings indicated that sometimes the staff team's communication and morale was not positive.

There was also no deputy manager in post and part of the time the running of the service was the responsibility of team leaders who were not qualified to manage the service and had other full time roles of their own. The provider told us they wanted to take action to improve these areas and had plans to recruit a new full time permanent manager for the service, although they indicated that this person may not be in post for several months. The covering manager offered to add the service to their registration with CQC but could not guarantee they would spend more time at the service.

Some people we spoke with told us they did not know who was in charge of the home. Others who had met the covering manager said that they liked this person and felt they listened to their opinions. Their comments included, ''He is a nice fella'', ''If I had a complaint I would speak with the governor'', ''The manager is excellent and he gets things done'' and ''The senior staff are very good.''

The local authority carried out monitoring visits of the service. In their most recent visit in August 2017 they had identified some areas of concern, which included a lack of specialist training for the staff and people using the service needed to be more involved in reviewing their care. The provider had created an action plan and had shared this with the local authority. There was evidence that they had started to address areas of concern which had been identified.

The provider had quality monitoring systems which included audits by the staff and additional monitoring by the provider's representatives. The visits conducted by the provider's quality team were designed to look at the key questions asked by CQC and test whether the service was meeting these. During the most recent quality audit the provider had identified areas requiring improvement. They had taken action to address these and we saw evidence of improvements in all of the areas identified. The findings of the provider's most recent audit which took place in January 2018 included similar findings to those we identified. In addition they had identified other concerns which had already been addressed and put right.

The provider's representatives worked closely with the service monitoring improvements. The covering manager provided analysis of accidents, incidents, infections, changes in weight and other significant events each month. In addition they undertook specific audits of the service which included looking at infection control, record keeping, dementia awareness, medicines management and mealtime experience.

The provider asked people living at the service and other stakeholders to complete satisfaction surveys regularly. The most recent survey had taken place at the end of 2017. The provider had published the results on notice boards around the home and had stated what action they would take to make improvements. There were regular meetings for people living at the service, their visitors and staff. Minutes of these meetings showed that people were informed about how the service was developing and asked for their views and opinions.

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 11 HSCA RA Regulations 2014 Need for consent The registered person did not ensure that care and treatment of service users was always provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always operate effective systems to assess, monitor and mitigate risks to service users or assess, monitor and improve the service. Regulation 17(1),(2)(a)(b)