

MGB Care Services Limited

Burlington Villa

Inspection report

15 Burlington Villa
Sherwood
Nottingham
Nottinghamshire
NG5 2GR

Tel: 01159602738

Website: www.mgbcareservices.co.uk

Date of inspection visit:
20 June 2022

Date of publication:
18 October 2022

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Inadequate 

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

About the service

Burlington Villa accommodates nine people in one adapted building. The service provides support to people with a learning disability. At the time of our inspection there were nine people using the service.

People's experience of using this service and what we found

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The service was not always able to demonstrate how they were meeting some of the underpinning principles of right support, right care, right culture.

Right Support

Staff did not always support people to have the maximum possible choice and control over their own lives.

The service had locked all internal and external doors to manage the behaviour of one person but consequently it impacted on other people's freedom. There was a wider concern relating to how the provider manages behaviours that challenge and whether the service supported a human rights approach.

Staff did not always support people with their medicines in a way that achieved the best possible outcome. The service did not maintain accurate and up-to-date records about people's medicines.

When 'as required' (PRN) medicines were used to manage behaviour, records were not thorough or detailed. There was no evidence of post incident analysis or evidence of how well the medicines were effective in managing the behaviour.

People were supported by staff to pursue their interests and make plans for the future.

The service gave people care and support in a safe, clean and well-maintained environment. People had a choice about their living environment and were able to personalise their rooms.

Right Care

Some people were able to express their views and make choices.

People received kind and compassionate support. Staff were appropriately trained and had completed training in autism and equality and diversity.

People had access to healthcare professionals and were supported by staff to attend appointments.

Care plans were person-centred and demonstrated a good amount of knowledge about the people they supported.

Right Culture

Restrictions were put in place with no evidence of the least restrictive options being considered. There was limited opportunity for staff to learn from incidents and improve practice.

Audits were completed at the home to monitor the service and make any improvements needed although they did not always identify shortfalls we found at this inspection.

Staff turnover was very low, this gave people a more consistent approach from staff who knew them well. Some staff members had been in post for several years.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for the service under the previous provider was good, published on 1st November 2017.

Why we inspected

We undertook this inspection as part of a random selection of services rated Good and Outstanding. 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.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to the safe care and treatment, safeguarding service users from abuse and improper treatment and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not always Safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement 

The service was Effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement 

The service was Caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement 

The service was not always Responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement 

The service was not always Well-led.

Details are in our Well-led findings below.

Burlington Villa

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

Two inspectors carried out the inspection.

Service and service type

Burlington Villa 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. Burlington Villa is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had about the service including notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We sought feedback from the local authority and professionals who work with the service such as Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 three people who used the service and three relatives about their experience of the care provided.

We spoke with four members of staff including the registered manager and the deputy manager.

We reviewed a range of records. This included four people's care records and five medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

Assessing risk, safety monitoring and management, Systems and processes to safeguard people from the risk of abuse

- People's movements around the service were restricted. We found all internal and external doors were locked preventing people from accessing their bedrooms, communal bathrooms, toilets and the kitchen. This action had been taken to manage one person's behaviours. Some people had their own bedroom key, but people had to ask staff to unlock other locked rooms. This was not proportionate and deprived people unnecessarily of being able to freely move around their home.
- The registered manager told us they had tried everything to manage these behaviours but there were no records to show that. We did not find any evidence that this level of restriction was a balanced response to the risk of any person's behaviours.
- Meaningful reviews of people's needs did not consistently occur. There was insufficient recording and reviewing of behaviours where a person had experienced distress. This included when people had been given medicine to manage behaviour and when incidents had gone on for long periods of time. Incident forms with a chance to debrief and reflect were only completed for severe incidents or when physical intervention had been used.
- Some people had complex conditions which required a 'positive behaviour support plan' (PBS.) PBS is a person-centred plan that promotes quality of life and helps staff to support people in distress to keep them safe. However, one person's plan did not include all the essential information which meant that techniques used were not always effective.
- One PBS plan did not document the use of chemical restraint for a person. When chemical restraint was used, the records were not detailed enough to evidence it was justified or reviewed properly.

The provider and registered manager did not carry out appropriate assessments to ensure that restrictive practice was a proportionate response to the risks identified. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Personal emergency evacuation plans did not include enough detail to keep people safe in case of a fire. The registered manager showed us a new template with more detail that was going to be used in the future.
- Risk assessments relating to a variety of identified risks including self-harm, oral health and finances were in place and regularly reviewed. The assessments had clear actions staff should take to reduce risk and keep people safe.

Using medicines safely

- Medicine stocks were not safely managed. We checked four 'as required' (PRN) medicines and found that

three of the balance checks for the medicines were incorrect. The provider's medicine policy stated weekly balance checks should be carried out, however these were not completed. This meant that people's PRN medicines could not safely be accounted for.

- When PRN medicines were used, the reason was not always recorded. For example, one person was given Lorazepam, but the reason for administering it had not been documented. This prevented the provider from monitoring the use of PRN medicine that was being used to manage behaviour.
- Medicine stock takes were not completed. We saw no evidence of running balance checks after daily medicines had been given. This meant that it was not possible to check for potential errors which could put people at risk of harm if not picked up quickly.
- Medicine administration records (MARs) were not consistently completed. We reviewed four people's MARs and found there were gaps in the records. We could not be assured people were always receiving their prescribed medicines.
- Medicines were not always stored in line with best practice. For example, we found medicines that needed to be returned to pharmacy on the floor of the medicines room. This meant when the room was unlocked or in use anyone could have access to those medicines.

We found no evidence people had been harmed, however medicines were not always safely managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were enough trained staff to meet people's needs. The registered manager told us they sometimes employed temporary staff but aimed to book regular staff to help ensure continuity and rapport with people.
- Staff were safely recruited. Pre-employment checks such as Disclosure and Barring Service (DBS) had been completed before staff started work. Checks provide information including details about convictions and cautions held on the Police National Computer.

Learning lessons when things go wrong

- When things went wrong, reviews and investigations were not always sufficiently thorough. For example, when people had emotional reactions that put others at risk, the provider did not always carry out reviews to make sure that actions from staff were safe and justified.
- There was insufficient learning from events that put people at risk. After incidents, staff did not review what could have been done better to improve the outcomes for people.
- Staff knew how to report incidents and accidents to management. We saw most reports had enough detail to outline what had happened and the actions they had taken.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- The provider had visiting arrangements in place that aligned to government guidance.



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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Care plans did not always contain guidance for staff. We found that one person's PBS plan did not contain the common triggers that caused emotional responses for that person. It did not contain all the agreed actions that staff could take when people were putting themselves and others at risk. This meant staff did not always have guidance on how to safely meet people's care needs.
- Most people and their families were involved in the assessment process. Further work however was needed to ensure the care planning process was accessible to everyone. A relative told us they were unable to attend meetings at the care home so had been unable to be part of their family member's reviews. Including relevant people and working together can achieve better outcomes for people.
- Assessments were personalised. Information regarding people's health needs and how they should be supported was available to staff. Information about people's communication and sensory needs was also included. This meant that staff had relevant information and understanding about how to support people.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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 any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider did not always work in line with the principles of the MCA. The provider had locked all internal doors which meant some people's freedom was restricted against their will. Mental capacity assessments had been completed around this decision however, the provider did not include all significant

information to ensure decisions met the statutory requirements of the MCA. This meant relatives and other relevant individuals were not able to make informed decisions on behalf of people in their best interests.

- Assessments had not been completed before the internal doors had been locked. There was no evidence of it being the least restrictive option which meant people were at risk of controls that could have been avoided.
- We found the service had legal authorisations in place to deprive a person of their liberty. The requests which had been approved to deprive a person of their liberty did not explain that all internal doors were locked. The requests did not state that keys some people had only opened their bedrooms and no other locked rooms. This meant that people's DoLS authorisations had been approved without the correct information being shared. This put people at risk of unnecessary restrictions.
- The provider was following current legislation around exploring sexual and social understanding. This is designed to support people with a learning disability to achieve the same rights as others on sexuality issues. The registered manager was working with other professionals to ensure one person was able to consent to sexual relationships.

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

- We saw that food was home cooked and of good quality. There were two options available at mealtimes, however people could request something different. The registered manager told us, "We don't like to have menus as people can choose what they like."
- People's risk of choking was assessed. Staff supported a person with complex needs and swallowing difficulties by following guidance from the speech and language therapy (SALT) team. This meant the person was kept safe from the risk of malnutrition and choking.
- Monitoring systems were in place. When people were at risk of malnutrition and dehydration, the staff recorded food and fluid intakes and people's weight was regularly recorded.

Supporting people to live healthier lives, access healthcare services and support care.

- People were referred to healthcare services when required, however some people were not supported to be fully involved. For example, we found that information relating to these appointments was not in an easy to read format so people could not always understand what had been said or agreed. After inspection examples of easy to read versions of information was provided.
- Care plans included specific information relating to people's healthcare needs. We saw correspondence from health care professionals which evidenced collaborative working.

Staff support: induction, training, skills and experience

- People were supported by trained staff, for example, staff had training in Autism and mental health. A staff member told us that, "Training is good and frequent."
- Inductions were completed for new starters including agency staff who were working in the care home for the first time. This helped to ensure staff had relevant knowledge about the service and people living there.
- Staff received support in the form of regular supervisions and appraisals. The appraisals encouraged staff to identify their own training needs so they could support people better.

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

- The home was clean and communal living rooms were nicely decorated. There were ongoing plans to ensure the decoration was refreshed when needed.
- The outdoor space was large with places for people to sit and eat. The registered manager told us there were further plans to adapt and improve the garden.
- People were supported pre-admission to visit the home and plan how they would like their room to be decorated. One relative told us their family member didn't like their bedroom at first, so staff supported

them to adapt it to their style.

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 outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider failed to put systems and processes in place to ensure people were always treated in a caring way. Despite these shortfalls we found staff were caring towards people. A person told us, "Staff are great. I can't wait till my birthday; they will have a party for me."
- Staff knew people well and had good knowledge of individual's likes and dislikes. The provider had retained staff for several years which gave consistency for the people who lived at Burlington Villa.
- We received positive feedback from relatives about the caring nature of staff. One relative told us, "[Person] likes it because they are good and caring. I have no concerns whatsoever. They really do what they can."

Respecting and promoting people's privacy, dignity and independence

- People were not able to be independent in their own home. The kitchen was locked when not in use which meant people could not help themselves to snacks and drinks without asking staff first.
- Staff had completed dignity and respect training however; the locked door practice did not support people to have a sense of dignity.
- Although people's movements were restricted in their home, staff supported people to go out into the community. One person told us, "The best thing about here is food and trip outs. We do a lot of them. We can do whatever we like."
- People were supported to have visitors. One relative told us the provider had made sure there was a lounge available, so they had some privacy to catch up with their family member.

Supporting people to express their views and be involved in making decisions about their care

- There were systems in place for people to share their views. People were invited to monthly resident meetings, however we found examples in meetings where people had been reminded they were not allowed in certain rooms because of past behaviour.
- Resident feedback forms were available; we saw examples where people had been supported by staff to complete these. There was evidence of the provider listening to people and acting on this feedback.
- One person had an independent advocate. This meant that person had someone who could support them to express their views and uphold their rights.

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 good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Staff did not always follow care plans. People with more complex needs had PBS plans in place. We found however staff did not consistently follow the plans which increased the risk of people becoming distressed, or a risk to others.
- Staff provided support that was flexible according to people's needs and wishes. One person did not always like to go out, their family member told us, "[Person] limits themselves, but staff are always there to motivate and encourage them to get out and about."
- Staff had supported people to go on holiday including abroad. Although people had not been able to go on holiday recently because of COVID-19, staff had encouraged people to make future plans.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information was not always accessible. We found information was not always provided in formats people could understand. For example, resident meeting minutes were in written format that only some people could read. Easy read versions of the service's complaints procedure and information on COVID-19 however were in place. This meant people may not have always had access to information to help them understand or make a decision. After inspection, examples of other easy to read versions of information was provided.
- There were no visual aids around the home to support some people to understand their environment. The registered manager told us they had tried symbols, but people didn't understand what they meant.
- People's care plans included information about how people communicated and what specific needs and methods were used. This meant staff had sufficient guidance to communicate effectively with people.

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

- Communication with relatives varied. We had a mixed response when talking to relatives about how their family member was supported to stay in touch. One relative told us they wanted the home to consider using other methods like regular video calls. Another relative told us, "I can always ring them up on the phone and speak to them, or they can ring me up."
- Social contact and companionship was encouraged. Relatives were welcomed into the home with one family member telling us they had visited recently for a Birthday party. The registered manager told us they

regularly invited people to events throughout the year, for example, summer barbecues and Christmas parties. This meant people were protected from the risk of social isolation and loneliness.

- Staff encouraged people to go out into their community. People were regularly supported to visit local pubs for food and drink. For example, one person did not like noise or crowds, so staff rang places first to ask if it was busy. This ensured the best outcomes for that person and encouraged social engagement.

Improving care quality in response to complaints or concerns

- The provider had a complaints procedure which was available in an easy to read format. We saw examples in monthly residents' meeting minutes where people were told how they could make a complaint.
- We looked at the home's complaints records. There had been no recent complaints raised.

End of life care and support

- People living in the home did not require end of life support. The registered manager told us they had tried speaking to some people about end of life planning and had started to include end of life information into care plans.

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems and process to monitor the service were not effective. Concerns identified during inspection were not identified and people continued to be exposed to risk of harm. For example, we found several shortfalls in medicine management that had not been identified in monthly audits.
- Vital information from incident forms had not been included in people's PBS plans to keep them up to date and relevant. This meant staff did not have all the information needed to keep people safe.
- Practice that deprived people was not identified. The provider failed to identify locking all internal and external doors was a disproportionate response to safely meet the needs of one person. This meant people's diverse needs were frequently overlooked because difference was not understood or acknowledged.
- The provider did not have a policy to support the locked door practice. This meant there were no clear guidelines for staff to follow which put people at risk of more restrictive practice.

The provider had failed to assess, evaluate and improve their practice to monitor and improve the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a poor culture in the service. Staff did not always consider a person-centred approach. For example, in some records we saw staff reminding people about 'bed-times' and 'routines.' This practice does not empower people to have independence or control.
- Management were approachable. Relatives and staff felt able to raise any concerns with the registered manager. One relative told us, "In my opinion the registered manager is an excellent manager, she is maternal and has the caring touch you need."
- Staff felt respected and valued by the managers. A staff member told us the managers were flexible so they could attend events important to their religious beliefs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were not consistently involved in running the service. Some family members told us they felt involved and welcome, but others felt the service could do more to include them. One relative told us, "They

had a review last year, but I have no idea what it was about, what was discussed or decided."

- We reviewed three staff meeting minutes where information was being shared with staff. We did not find examples in meetings of managers requesting input although staff told us they would feel happy to make suggestions. Sharing information and encouraging teamwork can help to achieve good outcomes for people.

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. Working in partnership with others.

- The provider understood their legal responsibility to be open and transparent with people. When something went wrong the registered manager was open and honest with family members. A relative told us, "I was involved with how it was managed; the manager was very open and rang me up and told me what had happened."

- The registered manager understood how to report notifiable incidents to relevant agencies, including the local authority and CQC. They told us when they would involve and notify other people.

- The registered manager worked in partnership with health and social care professionals to ensure people received support to meet their needs. For example, there was evidence of psychiatrists and SALT teams being involved for some people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had failed to assess and evaluate their practice to monitor and improve the quality of the service.</p>

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not assessed or monitored the use of restrictive practice.

The enforcement action we took:

Warning notice