Burleigh House Limited

Burleigh House

Inspection report

Burleigh House
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Burleigh House is a residential care home providing accommodation and personal care to up to 15 people. The service provides support older people who may be living with dementia, mental health needs and/or a physical disability. At the time of our inspection there were 13 people using the service.

People's experience of using this service and what we found
Medicines were not always managed safely as 'when required' medicines were not always administered in line with the prescription. There was often missing guidance for 'when required' medicines. Risks were not always assessed and planned for. Lessons had not always been learned when things went wrong, as action was not always taken when building safety defects had been identified. People were generally protected from cross infection, but the non-wearing of masks by some visitors (which was their own choice) had not been assessed. There were enough staff, so people were not unsafe, but further consideration was needed to ensure people had meaningful activity. Staff were overall recruited safely however further improvements were needed to ensure references were sought from most recent employers. People felt safe and were protected from the risk of abuse.

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. One person on covert medicines did not have this fully assessed and reviewed.

Quality assurance systems were not always effective at identifying areas for improvement and at ensuring action was taken when concerns were noted. Building safety checks had not always been undertaken in a timely manner. The registered manager understood their duty of candour. People, relatives and staff were asked for their opinion. Relatives and professionals were positive about the registered manager and felt the service worked in partnership.

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

Rating at last inspection and update
The last rating for this service was requires improvement (report published 28 January 2021). At this inspection we found the provider remained in breach of regulations and remained rated requires improvement.

Why we inspected
We carried out an unannounced focused inspection of safe and well-led at this service in December 2020. Breaches of regulations were found in relation to safe care and treatment and ineffective monitoring systems. The provider was issued with warning notices for these breaches and had a deadline to be compliant by.

We undertook this focused inspection to check they had now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those breaches.

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. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has not changed and it remains requires improvement based on the findings of this inspection. We have found evidence that the provider still needed to make improvements. Please see the safe and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Burleigh House on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 and will take further action if needed.

We have identified breaches in relation to safe care and treatment and the monitoring of the quality and safety of care at this inspection.

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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Burleigh House

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
The inspection was carried out by one 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.

Service and service type
Burleigh House 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. Burleigh House 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
The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We approached Healthwatch for their feedback; Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not have any feedback to share. The local authority shared their feedback about the service. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and seven relatives about their experience of the care provided. We spoke with six members of staff including the registered manager, deputy manager and care workers. We also spoke with seven professionals who were involved in supporting people who used the service.

We reviewed a range of records. This included two people's care records and reviewed multiple peoples medicine records. We looked at two staff files in relation to recruitment. We also looked at a variety of records relating to the management of the service, including quality audits, incidents and building safety records. We had a video call with the registered manager and deputy manager after our site visit in order to seek clarification and to validate evidence found. We looked at training data and policies and procedures. We spoke to the nominated individual to ask them about how they monitored the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Medicines were not always managed safely. Instructions were often missing or not detailed enough for 'when required' medicines and some 'when required' medicines were not being administered in line with the prescription label.

● One person was prescribed medicine to be given 'when required'. There were no instructions as to the circumstances this 'when required' medicine should be given. Staff had been regularly administering this on a daily basis which was not in line with the prescription. One professional said, "They [staff] are using medication to manage [the person]." Another professional said, "[The registered manager] can be quite medication focussed at times and will ask us to consider prescribing certain medications, even though not [needed]."

● Another person was prescribed a 'when required' medicine which was also being given as a regular dose which was not in line with the prescription. The same person was prescribed some medicine in liquid form with specific instructions on the prescription label. However, the medication administration record (MAR) referred to the medicine in tablet form and the prescription instructions were different. This meant there was an increased risk of an administration error. The staff in the home had the ability to write a MAR to ensure the records matched the prescription label instructions, but they had not done this. Following the inspection, the registered manager explained they had asked the pharmacy to amend the MAR to match the type of medicine they were sending each month.

● Another person had multiple 'when required' medicines prescribed and there were no protocols in place to guide staff about when these should be administered, and the person would not have been able to communicate their needs.

● Some staff had not completed their medicines training, according to records and their feedback. This meant we could not be sure staff were fully trained. Following the inspection, the registered manager explained some staff had training in their previous jobs for other services, however the quality of this training had not been verified. The registered manager also explained staff had competency checks, however these checks had failed to identify the omissions noted above.

● Despite this, stock levels matched records so staff were recording what they were administering even though this was not always in line with the instructions.

Assessing risk, safety monitoring and management

● Risks to people were not always fully assessed and planned for.

● For example, people's weights were not always effectively monitored. There were gaps in recording, and they were not always monitored in a timely manner. People had lost weight and this had not been identified and referrals to other health professionals for a review of this had not always been completed. Following our

feedback, these referrals were made.
● Another person was at risk of constipation and could become unwell. There were no detailed plans in relation to this and no process in place should the person stop going to the toilet regularly.
● In another example, one person could become distressed. Their care plans stated to use diversion techniques, however there was no further detail as to what worked with the person. Also, when their distressed behaviours had changed, this had not always been reflected in their care plans. We observed staff attempting different activities with the person, but they did not always have enough time to spend with them. Following the inspection, the registered manager explained the person's needs were recorded in different documents. However, staff would not necessarily have the time to read information in multiple places.
● Checks were made on fire systems in the home and records showed fire drills were carried out. However, fire safety plans indicated all staff needed to have keys on them for the front door in case of emergency. We observed and staff told us staff did not always have keys on them which could put people and staff at risk.
● Despite this, there was a relatively stable staff team so staff could get to know people. Staff were aware of people's needs and how to keep them safe. One relative said, "There is continuity of staff. They know when my relative is having a bad day and they know what to do. They [staff] are brilliant." Another person said, "I know all their names and they know me. They are good to me."

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

● We found the service was not always working within the principles of the MCA.
● One person had covert medicines. These are medicines which are hidden in food or drink, so the person does not always know they are taking the medicine. The person's capacity to decide about taking their medicines had not been assessed. Despite the lack of assessment, professionals and relatives were involved in discussing the use of covert medicines, however this decision had not been reviewed despite it being in place for over a year. Covert medicines are a significant restriction so a decision to use them should be regularly reviewed.
● Another person had a tick list in place to consider their capacity, but it was not a full assessment and did not specify the decision being considered.

Learning lessons when things go wrong
● Accidents and incidents were being recorded. However, patterns and trends were not always analysed on a regular basis so there could be missed opportunities to learn and improve. We did not find anyone had come to harm as a result of this.
● Many checks had been carried out on the safety of the building. However, some checks were missing or had not been recently completed. For example, some electrical checks had not been completed and gas safe checks had gone out of date. A water hygiene assessment had been completed and some of the actions had not been completed. When we asked the registered manager about these, they said, "I apologise, we are a bit behind with that."

All of the above concerns constitute a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Visitors had chosen not to wear a mask, despite government guidance being to wear a mask whilst inside care homes. Some visitors were spending time in or passing through communal areas without wearing a mask and this had not been risk assessed. Visitors who had chosen to continue to wear masks had not been consulted on others who were no longer wearing masks spending time in the presence of their relatives in communal areas. Following our feedback, the registered manager put a risk assessment in place.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We observed people being given snacks without plates or serviettes which were being placed on unclean tables. This was unhygienic.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. A policy was in place; however, it made no specific mention of COVID-19 even though there was additional government guidance in place.

● 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 making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes

● The registered manager encouraged visitors and people were supported to keep in touch with their relatives. There were a range of visiting options available to suit people's preferences, such as in bedrooms or in a designated area with screens and outdoors.

Staffing and recruitment

● People did not have to wait long for support; one person said, "I use the buzzer if I want a drink or something like that. They [staff] usually come right away. It's the same at night-time, no problems."

● However, there were not always staff available to engage people in meaningful activity. Whilst people were not unsafe, we received some mixed feedback about staffing in the mornings, which tended to be a busier time.

● We received feedback that some people were supported to get ready early in the morning. We arrived early to check this and did not see evidence in communal areas of this, however not everyone was able to communicate with us. We received feedback from multiple different staff that this was common practice however relatives did not raise any concerns with us about this.

● Staff were generally recruited safely. However, this could be made more robust. References from most recent employers had not always been requested, which is a requirement where possible and only one reference was on file. However, staff had checks on their identity and Disclosure and Barring Service (DBS) checks. DBS provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse and told us they felt safe. One person said, "I feel safe because they keep an eye on me." Another person told us, "I feel safe here because there are people about and I am not on my own."

● One relative commented, "We are confident our relative is being well looked after and they are safe here."
● Staff understood their safeguarding responsibilities. They were aware of different types of abuse and the need to report concerns if they had any.
● The registered manager had reported concerns when they had occurred, as necessary.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

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

- At the last inspection, we issued warning notices due to breaches of regulation. We checked whether the provider had rectified the concerns in these warning notices at this inspection. Some areas had improved; however, they were not fully resolved despite our inspection being after the deadline for compliance and there were additional concerns. This meant the provider had failed to continuously learn and improve.
- Quality assurance systems were not fully effective at identifying or making improvements.
- Some care plans and risk assessments were missing, lacked detail or contained out of date information and this was not always identified.
- Risk assessments were sometimes missing, and it had not been recognised that these were needed. Such as a person who suffered from constipation and there was limited guidance in relation to this and there was no risk assessment associated with visitors choosing to not always wear face masks whilst in communal areas.
- For example, the registered manager told us about one person who needed thickened fluids. The details of this had not been recorded in their care plan so there was a risk they could be given fluids that were not the right consistency. In another example, another person had been assessed as needing weekly weights at one time, but their weight had stabilised, so this had changed to monthly weight checks. Care plans were not consistent about this.
- The safety of the building was not always checked at appropriate intervals and timely action was not always taken when areas to address had been identified. For example, gas and electrical checks were not always done on time. A water hygiene assessment was carried out in March 2021 and the provider had failed to complete all of the actions identified. Some checks had identified the water temperatures were going over the safe recommended temperature and action was not taken to address this. Following our feedback, temperatures were fixed to be within a safe range.
- Systems were not consistently used to ensure people were appropriately supported. For example, people had lost weight. People's weights were reviewed periodically, but these had not always been monitored regularly enough and had failed to recognise some weight loss. These periodic reviews had not ensured referrals to appropriate professionals in a timely manner.
- A training matrix was now in place since the last inspection; however, it identified several gaps in staff training. Staff had not completed training about diabetes, despite multiple people having the condition. The registered manager was unaware of the Malnutrition Universal Screening Tool (MUST), which is a standardised, nationally recognised method to monitor people who are at nutritional risk. Following our

feedback about people's weight loss, the registered manager became more familiar with this.
● The provider explained they regularly visited the home and discussed areas for improvement with the registered manager, however they were not able to demonstrate how they monitored the service as they did not record any checks.
● The provider and registered manager had failed to submit their Provider Information Return (PIR). This is an annual requirement to submit information about the service.

The above concerns constituted a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● The registered manager understood their duty of candour, they said, "It is being open and honest even when things go wrong."
● The registered manager was able to explain to us how they would investigate concerns and we saw things were reported as necessary.
● The registered manager notified us of events in the home, as necessary. The previous inspection rating was also displayed in the home. as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, relatives and staff were asked for their opinion about the care.
● There were surveys with relatives. The feedback from the most recent survey was largely about the external grounds of the home which needed improving in areas; these issues had not been resolved however this did not have an impact on people living in the home. Newsletters were also shared with relatives to keep them updated.
● There were also staff meetings to discuss care and updates.
● The registered manager was able to explain to how they supported people with their protected characteristics, such as religion.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Relatives felt there was a positive culture. One relative said, "My relative is treated like family and we are treated like family when we visit."
● Professionals were positive about the home. One professional said, "I've got loads of praise. I think they are amazing. They do exactly what they are asked to do. The staff are very good here. I just think the care is amazing."
● Staff felt positively about the registered manager and felt supported. One staff member said, "[Registered manager] is brilliant, they are always hands on, we can just ask them. They are good with the residents."

Working in partnership with others
● The registered manager and staff worked in partnership with other professionals and organisations. One professional said, "They [staff] give us lots of information and working alongside us. It makes our job a lot easier." Another professional said, "I think they are very caring and very passionate about people."
● We observed a range of professionals involved with people's care.