Aps Care Ltd

Burlingham House

Inspection report

Dell Corner Lane
North Burlingham
Norwich
Norfolk
NR13 4EQ

Tel: 01603270600
Website: www.burlinghamhouse.co.uk

Date of inspection visit:
16 November 2016
17 November 2016

Date of publication:
02 March 2017

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

Burlingham House is registered to provide accommodation and care for a maximum of 31 older people At the time of our inspection there were 30 people living in the home.

The home did not have a registered manager in post. The manager had not submitted their application to become the registered manager. For the purpose of this report they will be referred to as 'the manager' rather than a 'registered manager.' A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 7 and 8 of October 2015, we asked the provider to take actions to make improvements to the systems they had in place to ensure that people's nutritional and hydration needs were being met and to act in accordance with the Mental Capacity Act 2005, and this action has been completed.

During our inspection we identified two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014

A breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 was found regarding the management of risks to people's health and welfare. People's risk assessments and care plans were not updated to reflect people's most current needs and action was not always taken to mitigate risks to people's health and welfare. Risks associated with the environment of the service were also not monitored.

There was a lack of effective systems in place to monitor and assess the quality of service being delivered. Audits to monitor and assess health and safety and people's care were not carried out and the provider did not complete any audits. These findings constituted a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The manager was candid about the improvements that were needed to take place and had developed systems which would be implemented to assess all aspects of the service.

You can see what action we told the provider to take at the back of the full version of the report.

We found that staff working at Burlingham House did not always act in accordance with the Mental Capacity Act 2005 (MCA) and MCA assessments were not detailed. There was little detail in people's care plans to detail how people should be supported with making choices and what choices they could make for themselves. Staff did not have a good understanding of the MCA and how to apply it in their work with people.

The staff were not always caring and some staff did not speak to people in an appropriate way. On the other hand, other staff were caring and attentive to people's needs and wishes and provided reassurance where needed.

Accidents and incidents were not consistently recorded and there was no system in place to monitor and analyse this information.

There was enough staff to support people and people's dependency was assessed on a regular basis so staffing levels could be adjusted accordingly.

Staff were supported through regular training relevant to their role and could access additional training if they wished. Staff did not receive frequent supervision to help them develop in their role. Staff felt supported by the manager and their colleagues and attended regular staff meetings.

Staff had received training in safeguarding adults and were aware of the correct procedure to follow to report concerns. The manager was proactive in addressing any safeguarding concerns.

People's relatives and friends were welcomed and in Burlingham House and there were few restrictions on the times people could have visitors.

There was clear leadership in the home and staff were aware of who was in charge of each shift and who they should report any concerns to.

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 consistently safe.

Medicines were not always managed or administered in a safe way.

Steps to identify and manage risks to people's health and welfare were not always taken.

Accidents and incidents were not always recorded.

There were safe recruitment practices in place to ensure suitable staff were employed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not have a good understanding of the Mental Capacity Act (2005).

People were not always supported to access relevant healthcare professionals where concerns were raised about their health or wellbeing.

Staff did not always receive regular supervision.

Staff attended training courses relevant to their role.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated in a caring manner by staff.

People's dignity was not consistently promoted.

People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not updated to meet people's most current support needs.

There were limited activities on offer for people to partake in throughout the day.

Staff responded to people's needs in a timely manner.

There was a complaints procedure in place and people felt able to approach the staff or manager if they had a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were no systems in place to monitor and assess the quality of service being delivered.

The manager had introduced regular meetings for people, their relatives and staff.

The manager was approachable and open to discussion.

Burlingham House

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 November 2016 and was unannounced. It 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This 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. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We also looked at information we held about the service, including previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During the inspection we spoke with three people living in the home and the relatives of two people. We made general observations throughout the service of the care and support people received. We also spoke with the manager, the provider, three members of care staff and the kitchen staff.

We reviewed three people's care records and Medicines Administration Record (MAR) charts. We viewed three records relating to staff recruitment and training, induction and supervision records. We also reviewed a selection of records that related to the management and monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

We found a number of areas within the service that were not safe.

We looked at how the home managed people's medicines and we noted a number of shortfalls in this area. We saw that a person's medicines had been placed in a pot and were still in the medicines room, there was no label to identify who's medicines they were of when the medicines should be administered. A member of staff we spoke with knew which person the medicines were for and that the medicines should have been given in the morning. We looked at the person's Medicine Administration Record (MAR) chart and saw that staff had signed the chart to confirm the medicines had being given. This person had not received their medicines as prescribed. We also noted by looking at the stock of some medicines that these did not tally with the amount that was recorded as being available.

We also saw that a medicine had been discontinued for one person in July 2016 and this medicine had not been disposed of.

Whilst risks to people's health and wellbeing had been identified, the associated risk assessments were not regularly reviewed or updated to reflect the most current advice from other relevant professionals on how best to manage people's individual risks. In one person's care records we saw that they were at a high risk of developing pressure ulcers and they were also nutritionally at risk. There were no risk assessments in place to provide guidance on how best to manage and mitigate these risks.

We looked at how risks were being managed for people with specific nutritional needs. In one person's records we saw that the Speech and Language Therapy team (SALT) had recommended a fork mashable diet and a thickener to add to their drinks to reduce the risk of choking. We saw that the guidance relating to the thickener was not added to the person's care plan and the information about how to prepare their food was added over a month later. In addition to this, the letter making the recommendations was in a different part of the person's care records rather than being filed alongside their care plan relating to nutrition and hydration. Instead, there was a previous letter from the SALT team next to the care plan. This showed recommendations regarding a consultation in 2015 where the person was recommended normal fluids. The lack of clear up to date guidance for staff about how to mitigate the risk of choking meant that the person was at risk of unsafe care.

We also saw from the person's care records that they had been assessed as being at high risk of malnutrition. There was nothing in their care plan to guide staff how often the person's risk of malnutrition should be reassessed. We noted that the Malnutrition Universal Screening Tool (MUST) was used on a sporadic basis to monitor their nutritional needs. MUST is a five step calculator for determining nutritional risk. It also provides guidelines about how to support a person who is at risk of malnutrition. We saw that the person's nutritional risk had not been calculated between March 2016 and August 2016, there was another gap in the records between August 2016 and November 2016. This meant that the person's nutritional risk was not being monitored and they would be at risk of not receiving a timely referral to relevant healthcare professionals if their health deteriorated.

We saw from another person's care records that they had also been assessed as being at a high risk of malnutrition. There was no risk assessment in place to give staff guidance on how to manage this risk. We saw that their care plan stated that the person should be encouraged to eat small meals and to sit in the dining room. However, at lunchtime, we saw that the person was sat in the lounge and was given a sandwich to eat. They were not offered any encouragement.

We found that actions to manage the risk of malnutrition and dehydration were not always taken. Where it had been suggested in people's care plans that their intake of food and fluid be monitored, records showed that these were not always completed correctly. For example, one chart we looked at only noted what fluids the person had consumed and sometimes the entries were not dated. Where people's intake of food had been recorded, it was not clear what they had eaten. We saw from one person's chart that they had eaten half of their main course and half of their dessert. The charts also showed that people did not drink sufficient amounts to stay adequately hydrated. The entries on one person's chart showed that on one day they had only had 100mls of tea and 50mls of juice. Due to the lack of information recorded regarding people's nutritional and hydration intake, we could not be sure that people were receiving a balanced and nutritious diet as well as an adequate intake of fluids.

Risks in the environment were not consistently monitored and the gas safety certificate had expired and there was nothing to show that legionella testing had been carried out.

We saw that the recording of accidents and incidents was not consistent. We saw that accidents were not always recorded and that a review of the accident had not always taken place. For example, what preventative measure could be put in place to prevent future occurrences. The manager showed us a form that they had developed for auditing any accidents and incidents and said that they would be implementing a monthly review of accidents and incidents. This would allow them to identify any trends or patterns.

These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In spite of the care plans and risk assessment not being up to date, staff knew people's individual care and support needs and this could serve to mitigate risks to people's health and wellbeing. It is of concern that any potential new staff or agency staff would have to learn of people's care needs via other staff rather than being able to get a thorough overview from people's care records.

People we spoke with told us how staff support them with taking their medicines, "I have my tablets twice a day, the staff give them to me, sometimes they can be a bit late." Another person told us, "The staff bring my tablets to me and I take them."

We saw that there was a recent safeguarding incident; we reported this to the manager immediately. The manager sent the staff members concerned home pending an internal investigation and also reported the incident to the local safeguarding team. The manager spoke openly with us about how they intended to conduct the subsequent investigation into the incident.

People we spoke with told us that they felt safe living in Burlingham House. One person we spoke with told us, "Yes I feel safe living here, if I didn't I would speak to the staff, there was a carer who was abusive to me verbally, I told [staff member's name] and the carer was stopped coming into me, it happened a couple of times but the staff are alright now."

Staff we spoke with told us that they had received training in safeguarding and training records we looked at

confirmed this. Staff knew what constituted abuse and what potential signs of abuse they would look for. Staff were able to tell us what procedures they would follow in order to report any concerns of abuse. Staff told us that they had reported concerns to the manager before and felt that they had been listened to and that the appropriate action had taken place.

The manager showed us a dependency tool that they used to determine the number of staff needed in order to support people safely. They told us that there was a minimum of five staff on shift with four to five staff on at night depending on people's support needs. We looked at the staff rotas and saw that during one week in November 2016 and saw that there were only three staff on for four nights. We saw that during the day there were enough staff on shift. People told us that there were staff available when they needed them, "There is normally a staff member immediately if I need one, I press my buzzer." Another person we spoke with explained, "I don't see people walking down the corridor, but if you need help there would be somebody easily available." Staff we spoke with told us that they thought that there was always enough staff on shift to support people safely.

We looked at the personnel records for three members of staff. We saw that appropriate references had been sought and satisfactory police checks had been completed prior to them commencing their role. This meant that there were practices in place for recruiting suitable people to work at Burlingham House.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 were being met.

During our previous inspection on 7 and 8 October 2015 we found that mental capacity assessments were not completed in accordance with the Mental Capacity Act 2005 (MCA). Our findings constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found during our most recent inspection on 16 and 17 November 2016 that improvements had been made in this area and the provider was no longer in breach of this regulation.

MCA assessments for people were generic and consisted of a 'tick box' form which covered various areas of people's life, ranging from decisions about what to eat to more complex decisions such as being able to manage their finances. The MCA states that assessments should be based on whether a person has capacity to make a specific decision at the time it needs to be made. The assessments we looked at relating to people's mental capacity were not decision or time specific.

Staff we spoke with had a limited understanding of the MCA. They were unable to give us an explanation of the basic principles of the MCA. Staff were able to give us examples of how they gave people choices about simple day to day things such as what clothes to wear but were unable to show that they understood the process they would follow if a decision needed to be made in a person's best interests.

There was limited information in people's care plans about how they could be supported to make decisions for themselves. The manager had started to document in one person's care plan what steps should be taken if a decision needed to be made on that person's behalf. This record showed a clear rationale why that decision needed to be made for the person to keep them safe and also showed that other people relevant to the person had been involved in making the decision.

People we spoke with were positive about the food served at Burlingham House. One person told us, "The food is good, [the staff] come round and ask you what you would like, you have a choice in both the meal and the sweets." Another person explained, "The food is superb, I get too much, my family eat with me every week." We observed that the mealtime experience was pleasant and we saw that staff would offer people a

choice of drinks. The food looked appetising and there were two choices of main course and sweets.

When we asked people if they were supported to access healthcare professionals, we received mixed opinions. One person told us, "I can see a doctor if and when needed, with regards to the optician, I haven't had an eye test for four years, I haven't seen a dentist either." Another person we spoke with commented, "I haven't needed to be seen by the doctor, but I am sure if I needed a doctor [the staff] would get in touch with one." One person's relative told us that they had to take their relative to the hospital themselves when they became ill. We saw from people's care records that their health and wellbeing was assessed on a daily basis and referrals were made to other relevant healthcare professionals where concerns were raised about a person's health.

All new staff had to complete an induction when they started work at Burlingham House. One member of staff told us that they went through all of the necessary policies and procedures and got to know the people living in the home. They went on to say that they "feel supported". We saw from staff training records that an induction checklist was in place to ensure that a trained member of staff had completed the induction procedure with the new member of staff.

Staff training records also showed that staff received training relevant to their role. Staff also attended regular refresher courses. Staff told us that they thought that the training provision was good, "There's ample training for what we need, but the medicines training could have been more in depth." When we asked staff if they received regular supervision, we got a mixed response. One member of staff told us that they rarely received supervision and the last time they received it was, "A good few months ago." Another member of staff told us that they received supervision every 12 weeks and they were able to request any additional training that they would like to attend.

We looked at supervision records and these showed that staff had not received any supervision since April 2016. The manager showed as a new spreadsheet they had developed to keep track of staff supervisions and appraisals. They told us that they were going to introduce six supervision sessions a year, but would increase these sessions if a member of staff required more, for example if a member of staff was having difficulty with their work.

Requires Improvement

Is the service caring?

Our findings

We found that some staff did not always treat people in a kind and caring manner. One person we spoke with told us, "[the staff] don't behave like carers or nurses, they are like family, there is a rough edge with some of them, I always feel that staff treat me with respect at all times. I like to think that they are patient with me but I don't push my luck." One person's relative told us that their relative had to replace their hearing aid 20 times as staff kept losing them.

During our inspection visit we heard one member of staff shouting at someone. We reported this to the manager who took the appropriate action. We also saw that when people became distressed some staff did not always recognise that people needed to be comforted. We saw people being moved in their wheelchair on a number of occasions and rarely saw staff speaking with people. We saw that people's care records were not always written in a dignified or respectful way. We saw one person's care plan described ignoring someone when they were displaying behaviour to seek attention. On the other hand, other staff would speak to people in a reassuring way and spend time listening to people. We saw that some staff would help to reassure people by holding their hand.

People's dignity was not always maintained. We saw that one person was sat in their room for over two hours with a plastic apron on. We saw another person asleep in the lounge on their own wearing a plastic apron. It was during the evening meal and we saw that their plate of food was in front of them but out of reach. We saw a dirty commode pot and dirty toilet in one of the bathrooms.

People's confidentiality was not always maintained. We saw that documents relating to the nightly checks that people received were left on the windowsills in the corridors.

People we spoke with told us that they felt listened to and were able to make their own choices. One person we spoke with explained, "I am listened to, [the staff] always ask me if I want a hand. Everybody is open with one another, it is my room and bathroom and I what I like. If [the staff] need to discuss anything in private, my son is usually here as well in the dining room, but if we were discussing money matters we would go to my room." Another person commented, "The staff are respectful and they have time to say hello, [the staff] are very caring and kind."

We asked staff what they thought was meant by person centred care. One member of staff told us, "It's how people want their care to be given, what they like to eat, if they want to do a specific thing, it's their wishes and you can't make people do things they don't want to." We saw that people were supported to be as independent as possible. We saw that people had mobility aids and adapted crockery to enable them to eat independently. Staff were able to describe to us how they supported people to be independent. We saw one person being supported by a member of staff to walk along a corridor, linking arms. We saw that they were chatting and laughing with the staff member.

We saw that people's relatives were welcomed by staff and people were welcome to have visitors for most of the day but staff told us that if people's relatives are not staying of a meal then it is preferred that people do

not visit during meal times.

Requires Improvement

Is the service responsive?

Our findings

People's care records we looked at showed that care plans were reviewed monthly, however we noted that where staff had documented changes in the review, the care plan itself was not updated to reflect the changes. For example, we saw from the review of one person's care plan that they now required the support of two staff with their personal care but the care plan still stated that they only required support from one member of staff. We also noted from people's care plans that they were not updated to reflect the most current advice given by relevant healthcare professionals. Whilst the letters stating the recommendations were in people's care records, the care plans were not updated.

Care plans were easy to read but lacked detail about how to support people individually. For example, we looked at some people's care plans relating to their living with dementia. It stated in some people's care plans, 'Carers to ensure that [person's name] is given basic daily choices.' This was a phase that was used in a number of care plans. There was no further guidance about what the best way of offering choice and when people were able to make these choices. We saw from another person's care plan that they experienced low mood at times. There was nothing in the care plan to detail what the signs of low mood were for this person or what support staff could give them when they were feeling low in mood.

Staff we spoke with were aware of the most recent information regarding people's support needs despite the care plans not reflecting these. Staff were able to explain how they would support people with their care and support needs. We saw during our inspection visit that staff were responsive to people's needs and saw that one person who was sitting in the lounge after lunch requested a different dessert, we saw that the member of staff offered them a choice and came back in a timely manner. On another occasion, we saw a person summoning a member of staff to ask them if they could help them with their hair later. We saw that the member of staff asked when they would like this help. We observed that some staff were quick to notice when people became upset and they would offer reassurance and talk to them.

We received varied opinions regarding the day to day activities at Burlingham House. One person we spoke with told us, "I enjoy travel books and I do my own exercises in the morning, there are no activities going on." One person's relative explained that they thought that their relative sometimes became bored due to the lack of activities and could go out more for a walk in the grounds. Another person we spoke with was positive about the activities offered, "I like to stay in my room, that is my choice. It used to worry [relative's name] but now they understand I am quite happy in my room, I like to watch films and listen to my music. I am always invited to join anything that the staff think I might enjoy." During our inspection we saw that people were taking part in a gentle exercise class in one of the lounges. We saw that staff were assisting people to make their way to the class.

People we spoke with and their relatives told us that they would be happy to raise a complaint with the staff or the manager. Relatives told us that they have raised concerns but one person's relative told us that these were not always acted on. Another person told us that they had attended one of the family meetings and were able to put forward their suggestions there. We saw that there was an appropriate complaints procedure in place which detailed the steps to be taken in the event of a complaint. The manager told us

that they had dealt with one complaint since they had been in post but did not keep a log of this. They explained that they had met with the person who wanted to raise their concerns.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well led. There was a lack of systems in place to monitor and assess the quality of service being delivered. Records we looked at showed that a care plan audit had been carried out in October 2016 but this did not pick up the shortfalls in people's care plans. Therefore, the audit was ineffective at identifying areas of improvement. There were no health and safety audits carried out and we were told that the gas safety certificate had run out in September 2016, and there were no legionella safety checks. The manager told us that they had arranged for a gas safety inspection. We asked to see any audits carried out by the provider. We were informed that there were no records of this.

Audits of people's medicines were not carried out regularly. Such audits would identify any bad practice in the safe handling and administration of people's medicines. Some people were prescribed pain medicines in the form of a patch that was placed on their skin. We saw that people received this medicine; however there was no record to show where the patch had been placed on the person's body. This type of medicine should be placed on a different place on the person's body when it is reapplied.

We noted that some people were prescribed PRN medicines. A PRN medicine is a medicine that people take when they require it, for example, a pain relief as and when they need it. We saw from people's MAR charts that when they had been given a PRN medicine, the reason for this had not been recorded. It is important to keep a record of PRN medicines given as it could show that a person may need to be referred to an appropriate healthcare professional if they are starting to request this medicine on a more frequent basis. Therefore, staff were unable to accurately assess people's PRN usage and make the appropriate referrals.

Records showed us that some people were prescribed topical creams. Information and guidance on how to administer creams should be recorded in people's MAR charts. Staff also informed us that people have separate charts in their rooms where staff would sign to say that they had applied the person's cream. We saw from the person's MAR chart that the cream should be applied twice a day but there were no instructions about when or where the cream should be applied. We asked to look at the cream chart for this person and we were told that there was no cream chart for them. We saw from another person's MAR chart that they had been prescribed a cream to be applied twice a day. When we looked at the cream chart for this person we saw that there was no guidance on when and where the cream should be applied. We also noted from the chart that there were a number of gaps on the chart where staff would sign to show that they have applied the cream. We could not tell from the chart whether creams had been applied as prescribed.

We spoke with the provider regarding the lack of auditing and they informed us that the previous manager would not inform them of any problems within the service, in spite of them being available to support the manager.

Due to the lack of systems in place to regularly monitor and assess the quality of service being delivered we could not be sure that risks to people, the staff and the environment could be promptly identified and managed. This was because the provider and the manager did not have a good oversight of the various processes in the home.

These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was able to show us the updated medicines management policy and the audit tool that they would use to monitor and assess the safe handling and administration of medicines. They told us that they would carry out a full audit of people's medicines. They were also able to show us blank copies of the audit forms that they had developed and told us that they planned to implement audits of all areas of the service within the next month.

The manager did not always send us statutory notifications of incidents. A notification is information about important events which the provider is required to tell us about by law. We did not receive a notification from the manager detailing the action they took regarding the safeguarding incident we saw during our inspection visit. We had told the manager during our inspection visit that we would require them to submit a notification of this incident.

As a result of our previous inspection carried out on 7 and 8 of October 2015, the provider and registered manager at the time were required to submit an action plan stating how they would improve the areas of the service where we found breaches of the regulations. We had received an action plan from the provider stating what they planned to introduce in order to address the issues. We asked the manager if they had seen this action plan and they told us they had not due to the previous manager not completing it. This demonstrated that there was not always clear communication between the provider and the manager.

There was no registered manager in post. The manager told us that they had not submitted their application to become registered manager as the previous manager had not deregistered. We spoke with the provider about this and they had not applied to have the previous manager deregistered but informed us that they would do this.

The manager had recently introduced meetings for people who live at Burlingham House which included a meeting for people's family and friends. The minutes of these meetings were yet to be typed up. People we spoke with confirmed that the meetings had taken place and one person told us how they didn't go to one of the meetings for the residents but they were represented by their family.

We were told by the manager that two staff meetings had taken place since they started in post, again there were no minutes of these meetings. Staff we spoke with said that regular staff meetings took place. One member of staff told us that the manager would call also call a staff meeting when they needed to share new information.

People we spoke with thought that the service was run well. One person we spoke with told us, "As far as I can see, things run well and not a need for alteration. Everything is clean, you have got a good bed, bathroom is well laid out and the food is good, I am quite happy being here." Another person we spoke with explained that there were not as many staff leaving now and that things had settled down.

Staff we spoke with told us that the manager was approachable and open to discussion. One member of staff told us, "You can just go and ask anything. Things are getting done, he's listening to us. Down to earth and really nice. Quite a lot of the families like [manager's name]." Another staff member commented, "[Manager's name] is doing a lot for the home." Staff told us that morale in the team was improving. We saw throughout the inspection that staff would approach the manager and just go and see them in their office as their door was always open.

We saw from the staff rotas that the staff member in charge of the shift was clearly named. We saw on the day of our inspection that the staff member leading the shift was visible and available to the people living in the home and staff. We saw that there was frequent communication about people's care between the staff.

When we spoke with the manager, it was evident that they had a clear vision of what improvements needed to be made at Burlingham House. They told us that they felt supported by the provider and had regular meetings with them to discuss the changes that they intended to make.

The manager spoke of developing more links with the community such as working alongside the district nurses and the falls team. On the day of our inspection, a member of the ambulance service was delivering some training to staff.

Feedback questionnaires were being developed to be sent out to people living in the home, families and healthcare professionals. This would give the manager a good oversight of what the service does well and what could be improved on.

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 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate steps to manage and mitigate risks to people's health and wellbeing had not been taken and there was a lack of systems to monitor and assess risks to people and the environment. Regulation12 (1) (2) (a)(b)(d)(e)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Suitable systems were not in place to monitor and assess the quality of service being delivered or monitor and mitigate risks relating to health, safety and welfare of service users and others who may be at risk by the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f)