Burlington Nursing Home Limited

Burlington Nursing Home

Inspection report

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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

This was an unannounced inspection which took place on 29 June 2017. We also returned on the 3 July 2017. The registered manager was given notice of the second date as we needed to spend specific time with her to discuss aspects of the inspection and to gather further information.

Burlington Nursing Home is registered to provide nursing and residential care for up to 40 older people who may be living with dementia. At the time of our inspection 29 people were living at the home. People's needs varied. Seven people were being cared for in bed. The majority of people residing at the home lived with dementia. 18 people required nursing care.

During our inspection the registered manager was present. 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 our previous inspection in October 2016 five breaches of regulation were identified. These related to staffing, personalised care, safeguarding, safe care and treatment and good governance. In response, the registered manager sent us an action plan that detailed the steps that would be taken to achieve compliance. The service was rated 'Requires Improvement' in the effective, caring, responsive and well led domains and 'Inadequate' in the safe domain. An overall rating of 'Requires Improvement' was awarded.

At this inspection we found that improvements had been made in all areas apart from record keeping. People still did not have accurate or up to date records for all their identified needs, records for monitoring fluids and positioning were not completed in full and some people's records contained conflicting information. You can see what action we told the provider to take at the back of the full version of the report.

People said that the registered manager was approachable and that improvements in the management of the home had taken place. Since our last inspection the quality assurance processes in the home had been reviewed and an increase in service audits had taken place. We found that where improvements had been made these needed to be fully embedded to help ensure people received a consistent service. Improvements had taken place to manage risks to people's safety but further work was needed. People's

records did not always evidence that known risks to their wellbeing were being monitored appropriately. On the second day of inspection, as a result of the feedback we gave on the first day, the registered manager had reviewed the system for monitoring people's positioning and fluid intake. This included changing the recording format, staff handovers and the frequency of audits. This gave us assurances that potential risks to people would be managed more safely.

Since our last inspection staffing levels had been reviewed and a dependency assessment used to decide safe staffing levels. During the inspection we observed a staff presence on both floors of the home at all times. However, there were two occasions when there were no staff present in the lounge and as a result people were left without the required assistance.

At our last inspection we received mixed feedback from people about the caring service provided to people. At this inspection the majority of people said that the service was caring. Despite people commenting positively we found that staff did not always practice a caring approach. We were given assurances by the registered manager that action would be taken in response to our findings.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. Policies and systems were in place to support this practice. We did note that some people's mental capacity assessments were not always decision specific or accurate. Information in accessible formats was not always available. We have made a recommendation about this in the main body of our report.

Staff said that they felt fully supported and that they received training and supervision relevant to their roles and responsibilities. Appropriate recruitment checks were undertaken before staff began work. Since our last inspection staff had been provided more training and the training programme had been expanded to offer further courses relevant to the needs of people who lived at the home. We did note that the frequency staff received formal supervision varied. We have made a recommendation about this in the main body of our report.

People expressed satisfaction with the meals provided. However, we observed that the support people received to enjoy their meal varied. We were given assurances by the registered manager that this would be addressed. Since our last inspection the registered manager had looked at ways of improving the nutritional and hydration needs of people who lived with dementia and had involved external professionals as part of this process.

People were happy with the support they received to access external healthcare professionals. Although care records were not always accurate we found that in the main their needs were being met. Staff followed safe medicine administration procedures.

People said that they felt safe living at the home. Since our last inspection staff had received safeguarding training and were able to explain the correct procedures that should be followed should they suspect abuse. Since our last inspection a safeguarding champion had been put in place and the home had signed up to West Sussex County Councils (WSCC) safeguarding champion programme.

Relatives said that they were welcome to visit their family members and people said that their views were sought on the care provided. People understood their rights to raise concerns and complaints. Formal systems for involving people were being reviewed in order to involve people further in decision making processes. People expressed satisfaction with the activities provided at the home.

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

Aspects of the service were not consistently safe.

People in the main expressed satisfaction with staffing levels. Sufficient numbers of staff were allocated on shift to provide safe care. However, the deployment of staff resulted in times when people had to wait for assistance.

Improvements had taken place to manage risks to people's safety but further work was needed to ensure this was applied consistently to everyone.

People said that they felt safe living at the home. Safeguarding procedures were in place that offered protection to people and staff understood their responsibilities in this area.

Medicines were managed safely.

Safe recruitment processes were followed.

Is the service effective?

Requires Improvement

Aspects of the service were not consistently effective.

Improvements to the provision of staff training had taken place to ensure staff were sufficiently skilled and experienced to care and support people to have a good quality of life. The frequency that staff received formal one to one supervision and appraisal varied and this is an area that would benefit from development.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and in the main followed the requirements of the Mental Capacity Act 2005. However, assessments were not always accurate and did not follow the MCA 2005 Code of Practice

People expressed satisfaction with the meals provided. People were supported to eat meals that promoted good health.

People said that they were happy with the medical care and attention they received. People were supported to access

external healthcare support as necessary.

Is the service caring?

Requires Improvement

Aspects of the service were not consistently caring.

People said that staff were caring. However, we observed that staff did not always practice a caring approach when supporting people.

Staff were able to explain how they promoted people's dignity and privacy. On occasions some people's dignity had not been promoted in full due to a lack of attention to detail with personal care.

People were supported to express their views and to be involved in making decisions about their care and support. Systems were being developed to enhance involvement further. Each person now had a personal profile that helped staff understand the person and to provide personalised care.

Relatives were welcomed in the home.

Is the service responsive?

Requires Improvement

Aspects of the service were not consistently responsive.

People said that they now received a responsive service and we found improvements had taken place in this area. However, people's needs were not always accurately assessed or planned for.

An activity programme was in place and people expressed satisfaction with the range of activities available. Further development of the availability of tactile objects and accessible information for people living with dementia will enhance the quality of service provided.

People felt able to raise concerns and were aware of the complaints procedure. Systems were in place that supported people to raise concerns and their views and opinions were acted upon.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

Improvements had taken place and systems were now being used to identify and take action to reduce risks to people and to

monitor the quality of service they received. However, as at our previous inspection records remained inaccurate and were not always up to date.

People said that management of the home and communication had improved and our findings confirmed this. Staff felt supported and were clear about their roles and responsibilities.

The registered manager promoted a positive culture which was open and inclusive.

Burlington Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 June 2017 and was unannounced. We also returned on the 3 July 2017. The registered manager was given notice of this date as we needed to spend specific time with her to discuss aspects of the inspection and to gather further information.

The inspection team consisted of one inspector, a specialist nurse consultant 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 checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We did not ask the provider to complete a Provider Information Return (PIR) as this inspection took place within six months of the publication date of our previous inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did however review the action plan that the registered manager sent us in response to the previous inspection. We received feedback from four external health and social care professionals on the service provided. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spoke with seven people who lived at the home and two visiting relatives. We also spoke with the registered manager, the deputy manager, one nurse, a laundry person, a cleaner, three care staff and the cook.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed the nurse giving some people their medicines and the lunchtime experience of people.

We reviewed a range of records about people's care and how the home was managed. These included 10 people's care records and six people's medicine records. We also looked at five members of staffs training, support and employment records, audit reports, menus, policies and procedures and accident and incident reports.

Requires Improvement

Our findings

At our last inspection breaches of regulation were identified and requirement actions made in relation to safe care, safeguarding people from harm and staffing levels. As a result, the Safe domain was rated as 'inadequate.' The registered manager sent us an action plan that detailed steps that would be taken to achieve compliance. At this inspection we found that steps had been taken and the breaches met which meant this domain was no longer 'inadequate.' However, further work was needed to ensure everyone received a consistently safe service and improvements were fully embedded.

People in the main expressed satisfaction with staffing levels. One relative said, "They seem to deal with problems quickly and if anything needs sorting and she presses the buzzer, a staff member comes and explains if mum has to wait." A member of staff said, "We did increase but decreased as we lost quite a few residents. We have four care staff in the morning, two up and two down. I think we need another. I think people's needs are met but we have limited time to spend just talking to people."

Since our last inspection staffing levels had been reviewed and a dependency assessment used to decide safe staffing levels. Staffing levels consisted of four care staff and one nurse during the day and two care staff and one nurse during the night. Since our last inspection in addition to this, a deputy manager had been appointed and a clinical lead nurse who both worked in addition to the care staff and nurse on duty. Separate ancillary staff were also allocated that included kitchen, domestic and activity staff. Therefore action had been taken by the provider to ensure staffing resources were increased across the home.

During the inspection we observed a staff presence on both floors of the home at all times. However, there were two occasions when there were no staff present in the lounge and as a result people were left without the required assistance. On one occasion this was for 20 minutes and the second occasion for 50 minutes. During these periods of time one person said, "I asked to go to my room some time ago, but no one has come." After 20 minutes a visitor went to find a member of staff to assist the person to their room and ten minutes later a member of staff came and assisted the person with their request to go to their room. On another occasion there was an altercation between two people who lived at the home. In order to stop this escalating we had to intervene and call for staff assistance. We also called the registered manager who agreed the lack of staff presence was not acceptable. We were informed that a rota would be implemented that detailed which specific staff would supervise the lounge and that a laptop computer would be purchased in order that staff could complete paperwork and still be located in the lounge.

When spending time with people in their rooms we observed that people had emergency call bells close to

hand in order that they could summon assistance if required. We noted that on the day of inspection staff responded promptly when emergency call bells were activated.

Appropriate recruitment checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This check helps to ensure staff are safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and references, job descriptions and identification evidence to show that staff were suitable to work in the home. We did note that one member of staff had commenced employment before their DBS check had been returned. During this period of time the person did not work unsupervised. The registered manager confirmed that a formal risk assessment regarding this had not been completed. This is an area for development that the registered manager agreed would help ensure people were protected from unsafe recruitment processes.

Improvements had taken place to manage risks to people's safety but further work was needed. One person's records identified that they were at risk of malnutrition and had skin integrity needs. Their care plans did not evidence that they were being weighed weekly and that they needed fortified foods as per the dietician's advice. However, there was documentary evidence on file that the dietician had reviewed the person recently and was happy with their dietary input and weight. This satisfied us that the risks in this area were being managed but that accurate records were not being maintained. This is reported on further in the well led section of this report.

When spending time with the same person we observed they had contractures to their legs and staff had not placed any aid between them to stop them rubbing. This was not in line with the instructions of the district nursing team who had instructed a cushion be placed between them. We also found that records were not in place that evidenced that the person was being turned in bed at the required frequency to reduce the risk of developing pressure areas. For example, on 23 April 2017 they were not moved for 12 hours and on the 25 April 2017 they were not moved for eight hours. Records confirmed that the person had pressure ulcers to their feet that had deteriorated from grade one and two to grades three and four. The same person did not have a care plan for mouth and teeth care despite other records stating they were known to suffer with periodic tooth pain. When spending time with the person we observed that their mouth and teeth were covered in food which suggested they had not received any support in this area. We shared our concerns about this person's wellbeing and safety with the registered manager who then raised a safeguarding alert with the local authority. On the second day of inspection, as a result of the feedback we gave on the first day the registered manager had reviewed the system for monitoring peoples positioning and fluid intake. This included changing the recording format, staff handovers and the frequency of audits. This gave us assurances that potential risks to people would be managed more safely.

We have since been informed that the persons care was reviewed by the home with the involvement of the community district nursing team, management of the persons needs had improved and as a result their pressure ulcers had reduced in grading.

For another person records evidenced that they had received the appropriate care to manage their skin integrity and pressure ulcer. For example, records included the description of treatment provided as well as photographs and measurements of the ulcer as it was being treated. We observed that where required, people who were being cared for in bed had pressure relieving mattresses in place. These were set at the correct setting for people's weight to help reduce the risk of pressure sores developing.

When incident and accidents occurred action was taken to minimise the chance of a re-occurrence. For example, as a result of one person falling, a referral to the falls prevention team was made and a sensor mat

was placed by their bed in order that staff could assist them quickly if needed. Another person was also referred to the falls prevention team in April 2017 and was awaiting their review at the time of inspection. Whilst awaiting this it had been identified that falls were linked to unitary tract infections (UTI) and additional fluids were being encouraged in addition to medicines to address the UTI.

Equipment was in place that was regularly checked to ensure it was safe to use. We observed that when bedrails were used protective covers were in place in order to reduce the risk of injury. Hoists had been serviced regularly and people had individual slings to assist with moving and handling. Small electrical items had been tested and a contract was in place to remove hazardous waste. There was a business continuity plan in place that would help minimise disruption to the service provided in the event of emergencies which included power failure.

People said that they felt safe living at the home. One person said, "I like living here, better than most." A second person said, "I feel safe here as the staff and management don't drink." A relative said, "Mum always smiles when carers come in."

Since our last inspection the registered manager had nominated the deputy manager to be a safeguarding champion and the person and the home have signed up to West Sussex County Councils (WSCC) safeguarding champion programme. WSCC informed us, 'The manager of Burlington expressed great interest in the Person Centred Safeguarding Champion Programme, has a nominated champion on this pilot and also attended the manager's event which was to ensure champions had full support of the manager. The Person Centred Safeguarding Champion has been fully engaged with the pilot programme.'

Staff received safeguarding training and were able to explain the correct procedures that should be followed should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One member of staff said, "You have to make sure immediately that no one is in danger. Definitely put in a safeguarding alert. If needed call police. Must inform X (registered manager) and CQC." A second member of staff said, "I would go and report any concerns to the nurse on duty. If not happy with what they do I would go to the manager. If I was not happy with what the manager did I would go to CQC."

Records confirmed that the registered manager had worked with other agencies where necessary to protect people from harm and abuse. Since our last inspection the registered manager had implemented a system for monitoring that the relevant safeguarding referrals were submitted to the local authority and when these occurred notifications were submitted to CQC. This helped ensure all relevant agencies were informed of events where necessary.

Staff followed safe medicine administration procedures. An external professional wrote and told us, 'I believe the administration of medication to be safe, the staff I've spoken to during my visits were knowledgeable and informed about both medication and their residents. I have on previous visits supplied the home with various supporting documents to help them manage medication and I have found that the home has been responsive to these and advice given and acted upon them.'

We observed the nurse giving people their medicines at lunch time. They wore an apron to say they were not to be disturbed while undertaking the medicine round, they locked the medicine trolley while it was unattended, and only signed Medicine Administration Record (MAR) charts when medicine had been administered. The MAR charts we looked at were completed accurately. Each included photographic identification of the person, known allergies were noted and there were no gaps of signatures seen. Codes were used to explain why a medicine was not given for example if someone was in hospital or out at the

time. Regular medicine audits were completed and staff received medicines management training.

Requires Improvement

Our findings

At our last inspection breaches of regulation were identified and requirement actions made in relation to consent to care and the Mental Capacity Act and staff training. The registered manager sent us an action plan that detailed steps that would be taken to achieve compliance. At this inspection we found that steps had been taken and the breaches met but that further work was needed to ensure a consistently effective service was provided.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People said that staff checked they consented to assistance before providing it. One person said, "The staff always ask, do you mind if I do this or that?" Since our last inspection the registered manager had taken steps to manage restrictions on people's freedom. Where necessary she had submitted a DoLS application to the authorising authority for people who lacked capacity and were unable to leave the home freely. As part of this process a mental capacity assessment had been completed which considered what decisions the person had the capacity to make. The registered manager had sought advice from the local authority DoLS team who had provided guidance on the detail needed when submitting applications to ensure applications were robust.

However, we did note that records contained conflicting information about people's ability to consent to aspects of their care and had the potential to impact on their legal rights being upheld. For example, one person's care plan reviewed in March 2017 stated that they lacked awareness, capacity and insight to participate in the decision to live at the home but their mental capacity assessment stated they had capacity to agree to this. When spending time with the person they told us, "This a nice home" and "Happy to be living here." This assured us that the impact on the person was minimal but was an accuracy of records issue. We have elaborated on concerns about accuracy and completeness of contemporaneous records in the Well-Led section of this report.

For another person their mental capacity assessment and care plan stated they had no capacity and insight

to participate in decisions regarding health and welfare and treatment. This statement was too broad and not in line with the MCA which states assessments must be decision specific.

The registered manager was enrolled on further detailed MCA and DoLS training which was planned for the day after our inspection to expand her knowledge in this area. This would also help to ensure MCA assessments were more accurate and followed the MCA 2005 Code of Practice.

Since our last inspection staff had been provided with additional guidance regarding the MCA and staff we spoke with demonstrated understanding of this and their responsibilities. One member of staff said, "Never assume someone doesn't have capacity just because they have dementia. You have to get to know the person." A second member of staff said, "Always put the person at the centre of their care. Support them to make decisions and do things in their best interest. When giving care ask which clothes they would like to wear. Look for non-verbal communication such as facial expressions."

People said that staff were suitably skilled to care for people. A relative said, "The staff have the skills to care. X (member of staff) has knowledge for looking after the elderly as a nurse." A second relative said, "Care staff look out for mum and know how to react when she is down."

Since our last inspection the deputy manager had been appointed as a dementia champion and had also completed train the trainer courses for dementia, moving and handling and safeguarding. A training programme was in the process of being implemented and the deputy was providing training to staff to enhance their knowledge and skills. Other training that was planned included end of life care, anticipatory grief and positive meal times.

The staff files that we looked at evidenced that staff had received training in areas that included fire, health and safety, infection control, food hygiene, first aid, nutrition and dementia awareness. All staff completed dementia awareness training as part of their induction. The registered manager informed us that all staff had been enrolled to undertake further in-depth dementia training with the aim of completing this by the end of August 2017.

The frequency that staff received formal one to one supervision and appraisal varied. Of the five staff records that we looked at two members of staff had received two supervisions in 2017. There was no evidence that the remaining three had received any supervision in 2017 and the registered manager confirmed this to be the case. Despite this staff said that they received sufficient support and training to undertake their roles and responsibilities. One member of staff said, "I've done infection control, health and safety, fire, dementia care. A second member of staff said, "I get support if needed." A third member of staff said, "We support each other as a team."

It is recommended that the registered person reviews and implements support systems to ensure all staff receive regular, formal supervision and appraisal.

People expressed satisfaction with the meals provided. An external professional wrote and informed us, 'They (people who live at the home) tell me that the food is nice and it always smells good cooking.' A relative said, "The food is a bit hit and miss, sometimes it does not look appetising and I always bring in fruit and sandwiches when I come."

We observed that the support people received to enjoy their meal varied. For example, we observed one person who was being assisted to eat by a member of staff who did not speak to the person at all whilst assisting them. The member of staff did not check to see if the person was ready for the next spoon of food

and did not interact with the person at all. A second person who was in a wheelchair, had their lunch brought to them and put on a movable table. However, the table was not moved to be above the arms of the wheelchair, and caused the person some difficulty to eat their meal as it was a long way from them. On the second day of inspection a member of staff was observed to check the height of the table and adjusted it so that the person was able to eat their lunch comfortably.

We observed other instances where people were given support to eat and staff showed consideration for the people they supported. For example, a member of staff explained to the person they were helping, what they were giving to the person and that it was going to be cold, therefore preparing the person for the experience. Another member of staff helped a person to drink through a straw. They encouraged the person and said "Have a break for a bit," "Can you have another go" and, "Are you all done now?"

On the first day of inspection everyone was seen to have the same meal of steak and mushroom pie, chips and peas apart from people who had pureed meals who had mashed potato instead of chips. On the second day people had sausage, mashed potatoes and vegetables. People were particularly complimentary about the meal served on the second day of inspection. One person said, "It's very nice." A second said, "It's delightful." A third said, "The sausages are very tasty." The meals provided reflected those stated on the menu. This did not give a second option but stated alternatives were available upon request. Staff confirmed that people were not routinely offered a choice of main meals. One member of staff said, "It's the same for everyone. We don't use pictorial or show plated options." This is an area for development to promote choice and inclusion for people living with dementia.

Since our last inspection the registered manager had looked at ways of improving the nutritional and hydration needs of people who lived with dementia. They had reviewed the provision of meals and snacks with the aim of increasing calories. The registered manager explained, "No one is on finger foods. The dietician was very much for three meals a day and aim for 200 calorie snacks per day and shakes." We spoke with the cook who was knowledgeable about the dietary needs of people. Information was available in the kitchen regarding people's likes and dislikes, meal size preferences, allergies and specialised diets. The cook was able to explain people's particular needs and preferences without the need to refer to records.

One external professional wrote and informed us, 'The manager also met with a member of the Care and Business Support Team when attending the Malnutrition Universal Screening Tool (impact on wellbeing) training. The conversation with our team member supported that the service was fully engaged to ensure good nutrition and hydration was provided in order to support peoples well-being.' Despite this we found some people's nutritional records were not accurate. This is reported on further in the well led section of this report.

People were supported to access external healthcare support as necessary. People told us that staff arranged for them to see professionals such as the doctor and chiropodist as necessary. The registered manager also ensured referrals were made to the falls prevention team, dieticians and district nurses where necessary.

Requires Improvement

Our findings

At our last inspection we received mixed feedback from people about the caring service provided to people. At this inspection the majority of people said that the service was caring. One person said, "The staff are ok, X (member of staff) is very caring." A second person said, "Some people are approachable." A relative said, "Staff are caring especially X (member of staff) who came and sat with mum when she was stressed and tearful, just came and talked." A second relative said, "Staff know everyone by name." One external professional wrote and informed us, 'In all interactions with residents that I have witnessed whilst in the home I found staff to be very caring.'

Despite people commenting positively we found that staff did not always practice a caring approach. When asked for their views about staff one person said, "They are not too bad, like human nature they vary. Some are not very kind, others are very nice." Staff did not always use language that respected people as adults or individuals. For example, they were heard referring to people who required assistance to eat in their rooms as "The feeds." One member of staff referred to one person as "A choker" when we asked about people who had thickened drinks to reduce the risk of them choking. On another occasion when a person asked if they could have a drink the response they received was, "What do you say? Please." When another person asked for something to eat the response was, "It is nearly lunchtime I will feed you in a while." We also noted that in records bedrails were at times referred to as 'cot sides.' This kind of language used to describe people and their needs did not demonstrate respect for people as individuals.

Staff did not always interact with people in a positive way. For example, when assisting a person to move the member of staff did not talk to the person and explain what they were doing. No words of encouragement and assurance were offered. On other occasions staff were seen and heard talking to people in a kind and positive way. For example, when one person was assisted to eat the staff member chatted to them and offered words of encouragement. We spoke with this member of staff afterwards and they demonstrated understanding of providing inclusive and personalised care. They explained, "We are to treat everyone as an individual. Just because someone has dementia we shouldn't label them. They are just people who we care for. It's about looking at ways of communicating. Being on their level."

Staff did not always ensure people's dignity was maintained. One person who was confined to bed was seen to have food around their mouth and teeth. Three people had dirty finger nails.

When we shared our findings with the registered manager they agreed the practice of some staff was not caring. She said action would be taken to address this. The registered manager showed us documentary

evidence of action that had been taken in response to our previous inspection and the approach of certain staff. This offered us assurances action would be taken in response to the findings from this inspection. On the second day of inspection we were informed that the member of staff who had not demonstrated a caring approach when supporting people was no longer working at the home. We were also shown documentation that had been reviewed and implemented that would help ensure people received sufficient support with personal care however we were unable to assess .

For other people, staff had ensured their dignity and comfort was promoted. For example, we saw that two people who were being cared for in bed had been covered with a blanket and staff had placed soft toys next to one person which the person was seen gently stroking. When assisting another person staff checked that they were comfortable in bed and when they said that they were not repositioned them until the person was satisfied.

There was a privacy and dignity charter displayed in the home that informed people of the actions that would be taken to ensure their rights were promoted. This included the use of a privacy screen to protect people in communal areas. When one person became ill and started to vomit in the lounge staff quickly went to their assistance but a privacy screen was not used and the registered manager confirmed that one was not available.

Since our last inspection the registered manager had arranged for each person who lived at the home to have a personal profile completed. These were kept in people's rooms and gave insight into people's backgrounds before they required nursing or residential care. The information helped staff understand the person, what was important to them and could also be used to promote personalised care for people living with dementia. For example, one person's profile gave information about places they had lived when they were younger, time they had served in the army, previous employment and details about people who were important to the person.

Relatives said that they were welcome to visit their family members. One relative said, "I can visit whenever I want to and feel ever so welcome." People's birthdays were celebrated with the cook making cakes and families invited. One relative said, "They made mum a lovely birthday cake and the carers came in to wish mum happy birthday."

People said that their views were sought on the care provided. One relative said, "I had a look at the care plan and made comments and things were changed." A second relative said, "I asked to come to a meeting with relatives and residents and I have filled in a couple of questionnaires." One person told us that staff respected their wishes with regards to personal care and always provided this in the way that they wanted. The registered manager confirmed that there had been no residents/relative meetings in 2017 and that this was an area for development. The registered manager informed us that they were looking to implement a twice yearly newsletter in order to keep people informed and involved in the service.

Requires Improvement

Our findings

At our last inspection a breach of regulation was identified and a requirement action made in relation to personalised care. The registered manager sent us an action plan that detailed steps that would be taken to achieve compliance. At this inspection we found that steps had been taken but that further work was needed to ensure the improvements were fully embedded.

People said that they received a responsive service. A relative said, "The staff went straight to get a nurse when we worried about mum's leg." A second relative said, "The care has been managed really well by the carers and they go the extra mile."

We spent time with one person who stayed in their room all of the time and they told us how they had recently moved to a different room which they were very happy about. They explained, "I'm very pleased with it all. I like this room much better than the other one and I can have the light on so I can see the television better." This person confirmed to us that it was their choice to stay in their room. They also told us that they had lost their bottom dentures and how they wished they could have a new set but that this was not possible as staff had advised them they would need to visit a dentist and the person did not wish to leave their room. When asked, the person said that they had not been advised of the possibility of a home visit from a dentist but that this would be something they would like. We fed this back to the registered manager who agreed to arrange this for the person.

Another person's records evidenced that as a result of the support they had received with their nutritional intake their prescribed nutritional supplements had been reduced from three a day to one. This demonstrated that they had received responsive care that promoted their wellbeing.

The contents of people's assessments and care plans varied in accuracy and detail. Some people had all the required documentation to inform staff and to ensure they received consistent quality care whilst others did not. Despite the omissions in people's records staff were able to explain the care and support that people required. This offered assurances to us that people received the care they needed but that records were not accurate and did not reflect this. This is reported on further in the well led section of this report.

Since our last inspection a poster to inform people about the Accessible Information Standard had been put on the first floor notice board. From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily

read or understand so that they can communicate effectively. We found very little evidence that the Standard had been implemented at the home and the registered manager confirmed this. There was a pictorial menu but the size of the menu including the font size was small which may make it difficult for people with visual impairments to read. There was a board in the lounge which had information in large font and included pictures about the weather. Personal profiles had been introduced for each person but these did not include the use of pictures or large font that would help people who were visually impaired or living with dementia understand what was written about them.
It is recommended that the registered person reviews and implements procedures that help ensure the Accessible Information Standard is fully embedded at the home.

People expressed satisfaction with the activities provided at the home. One person said, "I have been here nine years and I always have something to do. The entertainment is run properly and we had music yesterday." A second person who spent all their time in their room said, "I look at books and they put films on." One external professional wrote and informed us, 'There is a warm, relaxing environment at the Burlington. The front lounge, in particular, is very homely. I have witnessed residents watching T.V, drinking coffee and using colouring books in this room. I understand that the activities co-ordinator has spent a lot of time and effort making the downstairs rooms interesting and enjoyable. I haven't witnessed any joint activities but see lots of one-to-one interaction between residents and staff. The residents always look clean and presentable and seem relaxed in each other's company. I understand that they can go outside into the garden but maybe that's only with supervision.'

An external professional wrote and informed us, 'In particular, I have worked with X, (deputy manager), who seems very caring, has spent time supporting one of the individual's to identify hobbies/activities that he may be interested in and to research local opportunities. X then checked back with the client, about how he felt after the first visit. When X found out it hadn't gone so well, she was quick to find an alternative, which he now really enjoys X (registered manager) holistic approach; looking at use of distractions, sensory boxes, dolls and least restrictive options, has greatly impacted on the quality of life for that person. I have always found X (registered manager) to be approachable and open to suggestions. In addition, I would add that the home's staff are always friendly and any actions agreed are always completed in a timely fashion.' During the inspection sensory boxes and tactile objects of reference were not always easily accessible to people living with dementia as these were in a closed cupboard in the lounge. There was a rummage box located on the first floor but the lid to this was down. This is an area for development.

Since our last inspection a multi faith minister had been visiting people at the home two days a week. During their visits they spent time with people talking with them or sitting with them offering spiritual support.

A garden party took place on 30 June where families and friends were invited. Music from the 1950's was provided by an external entertainer which helped people who lived with dementia to engage and enjoy the event. Other activities and events offered at the home included creative talk visits by an external company who offer stimulation to people, fish and chip Saturdays and a hairdresser visits weekly to offer services to people.

A staff board had been introduced at the entrance to the home that contained photographs and titles of people so that visitors and people new to living at the home would know who staff were.

People understood their rights to raise concerns and complaints. One relative said, "We had a complaint and this was resolved straight away. They also emailed regarding sorting out the care plan."

Information of what to do in the event of needing to make a complaint was displayed in the home so that

people could raise concerns if they wished. The complaints procedure included the contact details of other agencies that people could talk to if they had a concern. These included the CQC. This information was also included in the home brochure which people were given a copy of when first moving to the home. Four complaints had been received since January 2017. Each had been investigated and responded to. Where necessary, action had been taken in order to reduce an issue reoccurring.

Requires Improvement

Our findings

At our last inspection a breach of regulation was identified and a requirement action made in relation to good governance. The registered manager sent us an action plan that detailed steps that would be taken to achieve compliance. At this inspection we found that although action had been taken this was not sufficient to ensure the breach was met in full.

Since our last inspection the quality assurance processes in the home had been reviewed and an increase in service audits had taken place. The registered manager had overall responsibility for monitoring the quality of service provided with key staff delegated the task of completing audits of certain areas. Monthly reports were then submitted to the registered manager in order that she could retain oversight and to ensure appropriate action was taken where necessary. Monthly audits had been introduced for areas that included people's dependency levels, falls and accidents, complaints, medicines, safeguarding and care plans. Evidence obtained from our inspection showed that improvements had taken place in areas that included staff training, risk management, application of the MCA 2005 and the care that people received. As reported on in other sections of this report we found that although improvements had taken place these needed to be fully embedded, over a period of time and sustained in order that all people received a consistent quality service.

Audits of care records had also taken place but these had not ensured sufficient improvements in this area and people still did not have accurate or up to date records.

As previously mentioned in the safe domain one person's records did not evidence that they were being weighed weekly and that they needed fortified foods as per the dietician's advice. Also records were not in place that evidenced that the person was being turned in bed at the required frequency to reduce the risk of developing pressure areas and they did not have a care plan for mouth and teeth care despite other records stating they were known to suffer with periodic tooth pain. A second person did not have a moving and handling care plan and their fluid monitoring and turning charts had not been completed in full. This person was at risk of choking and had specific continence needs. These two areas were referenced in other parts of their records but specific assessments and care plans were not in place. A third person with diabetes had a care plan but no assessment of potential risks for this condition. A fourth person had a risk assessment for the management of falls. However, this was not accurate as it did not reference the use of a sensor mat that was in place. A fifth persons MCA assessment and care plans contained conflicting information with some stating they did not have capacity to make decisions and others stating they did. This person had a care plan for nutrition which stated they were at risk. However, their malnutrition assessment scored then as zero

and their body mass indicator had not been calculated.

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

The registered manager acknowledged that recording keeping was not to an acceptable standard. When we fed back our findings she said, "I am deeply disturbed and disgusted. Record keeping is appalling." As a result of our feedback the registered manager made arrangements to review the processes for ensuring accurate records were maintained which gave us some assurances. However, we will not be able to confirm if sufficient action has been taken until we next inspect the home.

People said that the registered manager was approachable and that improvements in the management of the home had taken place. One person said, "She is the boss lady." A relative said, "The communication with the carers is excellent, they always tell me how mum is and has been. It has been difficult to speak with the management, but this has been improved." One external professional wrote and informed us, 'I have been a visiting health care professional at the nursing home for a number of years with the present owner and a number of previous owners. Most recently I have seen a gradual 'upgrade' of standards at the Burlington under the current management. Their leadership has ensured staff are caring, safety conscious and always willing to help me in my role. If I bring to notice any issues I feel that they are dealt with professionally.'

A second external professional wrote, 'I have always found the care manager and owner of the business very positive to advice given and the care manager herself has contacted me recently to ask for clarification around covert administration. We have been able to develop a good professional relationship over the period of my visits.' A third external professional wrote, 'All interactions with X (registered manager) have been open, approachable and very welcoming.'

Staff also said that the registered manager was approachable. One staff member said, "I find her fine. I can show my frustrations to her and things get dealt with." A second member of staff said, "It's fantastic here. Staff and management are like a big family and the owner is very good." A third member of staff said, "I like it here. Staff are helpful and the manager is very good." A fourth member of staff said that the registered manager was, "Supportive. She changed my rota to fit with my childcare needs." Staff meetings had taken place to keep staff informed and involved in the home.

The registered manager demonstrated an open and honest demeanour. When we brought to her attention a potential safeguarding situation she was apologetic and immediately raised an alert with the local authority. This demonstrated openness in line with Duty of Candour. Duty of Candour places a requirement on providers to inform people of their rights to receive a written apology and truthful information when things go wrong with their care and treatment. The registered manager was aware of the legal requirement to report significant events. As such, notifications were submitted to the Commission in a timely and transparent way. Staff were aware of the registered providers whistle blowing procedures and how this offered protection to people.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured accurate and up to date records were maintained in respect of each service user. 17(2)(c).