Miss Amanda Sutherland

Burlington Care and Support Services

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

About the service: Burlington Care and Support Services is a residential care home that provides personal care and support for up to 13 people with a learning disability. Accommodation is provided over two floors within two separate but adjoining buildings. At the time of the inspection there were 12 people living at the home.

People's experience of using this service:
We found the service was not operating in accordance with the regulation and best practice guidance. This meant people were at risk of not receiving the care and support that promoted their wellbeing and protected them from harm.

The provider did not have sufficient oversight of the service to ensure people received the care and support they needed that promoted their wellbeing and protected them from harm. Systems and processes to monitor the service were not effective and did not drive improvement. These included concerns with records, risk management, medicines, a lack of person centred care, infection control and the environment.

Staff told us people were encouraged and supported to use a range of healthcare services. We found the service were slow to seek advice or make referrals when people's needs had changed.

Whilst we did not find people were being disadvantaged, people were not supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible. Related assessment and decisions had not been properly undertaken. Where some people were subject to continuous supervision the provider had not applied for this to be authorised.

Staff felt supported and valued and received regular training. However, there was a lack of monitoring of this training to check if it was effective.

People told us they felt safe and well cared for. Staff afforded people respect and provided care and support with compassion. Relatives did not raise any concerns about people's safety and told us people were well cared for and looked after.

People and their relatives had confidence in the service and told us the home was well managed. One family member said, "I have no concerns about how the home is managed." Another said, "My experience has been a positive one, I have always found the manager and staff to be incredibly helpful."
Rating at last inspection: The service was previously rated as 'Required Improvement.' The report was published on the 16 February 2018.

Why we inspected: This was a planned inspection that was scheduled to take place in line with Care Quality Commission scheduling guidelines for adult social care services

Enforcement: We found repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have also made recommendations in relation to staffing levels, training and infection control. Please see the action we have told the provider to take at the end of this report.

Follow up: This is the third consecutive time this service has been rated 'Requires Improvement.' We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least 'Good.' In addition, we will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led

Details are in our Well-Led findings below.

Burlington Care and Support Services

Detailed findings

Background to this inspection

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

Inspection team: The inspection team consisted of one adult social care inspector on the first day and one adult social care inspector and an inspection manager on the second day.

Service and service type: Burlington Care and Support Services House is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had a manager registered with the Care Quality Commission. The registered provider is also the registered manager. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.'

Notice of inspection: The inspection was unannounced and took place on the 29 January 2019 and 5 February 2019.

What we did: Before the inspection we reviewed the information we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We also asked the provider to complete a Provider Information Return (PIR). The PIR is information we require providers to send us at least once annually to give us some key information about the home, what the home does well and improvements they plan to make. We used this information to plan the inspection. We spoke with six people living at the service, five members of staff, the service manager who managed the home on a day to day basis and the registered provider who is also

the registered manager. We asked the local authority who commissions care services from the home for their views on the care and support provided. Following the inspection, we received feedback from four health and social care professionals and five relatives. We also contacted South Devon and Torbay NHS Foundation Trust's quality assurance and improvement team (QAIT) as they had been working with the home following their previous inspection.

To help us assess and understand how people's care needs were being met we reviewed five people's care records. We also reviewed a number of records relating to the running of the home. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management: Premises safety:
•At the last inspection January 2018, we found risks to people were not managed effectively. At this inspection we found people's risks were not monitored or managed safely.
•Risks in relation to falls and skin breakdown were not being managed safely. There was a lack of detail around people's specific risks. For example, one person did not have a clear risk assessment relating to falls. Another person needed repositioning to reduce the risk of pressure ulcers but the lack of monitoring may mean staff would not take action when needed.
• Staff did not include information about the monitoring of risks in the daily handover to other staff.
• The premises were not safe as people remained at risk of scalding as the water temperatures were above the recommended temperature of 43 degrees centigrade. Records showed temperatures exceeding 43 degrees centigrade were being recorded but no action was taken.
• Windows above ground level were not restricted or risk assessed placing people at risk of falls from height. We brought this to the attention of maintenance staff who assured us they would act to mitigate this risk.
• Fire safety records showed routine checks on fire and premises safety were taking place. However, the provider did not have in place an up to date Fire Risk Assessment, which is a legal requirement under The Fire Safety Order 2005.
• People had personal emergency evacuation plans (PEEP). However, we found one person's PEEP had not been updated following a change in their health.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:
•Medicines due to be returned to the pharmacy for safe disposal were not stored securely. For example, medicines that were due to be returned to the pharmacy were stored in a place which could be accessed by all staff.
•Medication Administration Records (MARs) for one person showed they had been prescribed a pain relieving medicine. Staff were not administering this medicine as prescribed.
•Records did not contain clear guidance for staff as to when variable dose medicines should be used.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Audit systems were in place to check medication practices and clear records were kept showing when medicines had been received, administered or refused.

•Staff had received training in the safe administration of medicines and their competency was regularly assessed.

Preventing and controlling infection:
•People were not sufficiently protected against the risk of infection. Poor infection control procedures and the lack of clear workflow systems to separate clean and dirty laundry could lead to an increased risk of cross infection.
•The service was not clean in all areas, some chairs and sofas in the lounges were heavily stained and had an unpleasant odour.
•Records showed an infection control audit was being carried out monthly but had not identified these issues.

We recommend the provider undertakes a complete review of infection control procedures to ensure the service follows best practice guidelines.

•Staff had access to personal protective equipment (PPE), such as aprons and gloves, to reduce the risk of cross contamination and spread of infection. For example, whilst carrying out personal care or preparing food.

Staffing levels and recruitment:
•Recruitment practices were safe and included pre-employment checks from the Disclosure and Barring Service.
•Relatives and staff felt there were enough staff on duty to support people and keep them safe. The service manager told us that staffing levels were organised around each person's specific support needs and where people had been identified as needing one to one support this was being provided. However, the service did not have in place a system for determining how many support staff were needed in relation to the number of people who lived at the service and their level of dependency.

We recommend the provider uses a suitable tool to determine people's level of dependency to ensure that staffing levels are sufficient to meet people's assessed needs.

Systems and processes to safeguard people from the risk of abuse:
•People consistently told us they felt safe living at Burlington Care and Support Services. One person said, "I do feel safe, I like living here." Another said, "It's been good living here and the staff are great, but I'm ready to move on now." A relative said, "We have always been very happy with the place and from what we have seen people are safe and always appear to be well looked after."
•People continued to be protected from the risk of abuse. Staff attended safeguarding adults training and most staff demonstrated a good understanding of how to keep people safe.

Learning lessons when things go wrong:
•Accidents and incidents were recorded and reviewed by the service manager to identify any learning which may help to prevent a reoccurrence.
•Lessons had been learnt for example, following an incident with medicine. Staff now wore a red apron with the words, ''Do not disturb' to reduce the risk of being distracted when administering medicines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
Healthcare support:
•Care needs assessments identified people's needs and provided staff with guidance about how best to meet those needs in line with people's preferences. However, we found when one person's needs had changed the provider had failed to seek professional advice in how best to meet their needs in a way that protected the dignity.
•Staff told us that people were encouraged and supported to use with a range of healthcare services, including dentists and opticians. However, we found that some appointments or referrals were not always made promptly. For example, one person had waited five months for a referral to be made to a dentist. This meant the person had been left at risk of pain.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•People told us they had been involved in assessments and supported to make choices about their care. One person showed us their care plan and said, "This is all about me."
•Relatives spoke positively about the care and support people received. One relative said, "I do not have any concerns, they call the doctor if needed and they always let us know how [person name] is."

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 were not always supported to have maximum choice and control of their lives. For example, where the service held or supported some people to manage their finances as they lacked capacity. There were no mental capacity assessments to show that people did not have capacity to manage their finances or that the decision to hold their monies had been made in a person's best interests.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation

of Liberty Safeguarding (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

•Where restrictions had been placed on one people's liberty to keep them safe, the service manager worked with the local authority to seek authorisation for this. However, we found these principles had not been consistently applied. For example, other people were subject to constant supervision and their capacity to consent to these arrangements had not been assessed.

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

Adapting service, design, decoration to meet people's needs:
•Burlington Care and Support Services is set over two floors, within two separate but adjoining buildings. At the two previous inspections we found some areas of the home needed refurbishment. At this inspection we found improvements were still needed. For example, carpets remained worn, frayed and stained; some of the furniture was heavily stained, some walls needed painting and some areas of the home were not clean. We noted the lounge within the 'annex' where three people lived continued to be used as a storage area.
•The service manager and provider told us that a number of bedrooms had been redecorated along with a downstairs bathroom and assured us there was an on-going refurbishment plan.

This was a breach Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience:
•People told us they had confidence in the staff supporting them and relatives told us they felt staff were well trained.
•The provider monitored staff training on a training matrix. We found the training matrix had not been kept up-to-date and showed significant gaps in the training staff had received. This meant the systems in place to ensure staff had the necessary skills to carry out their duties were not effective and could not be relied on.

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

•Staff received regular support and supervision. Staff told us they felt supported in their role and could approach the service manager or provider for advice, guidance and support. Comments include; "We do have regular supervision," and "I feel very supported" and "I can speak to the [provider name] whenever I need to"

Eating, drinking, balanced diet:
•Staff were not familiar with important records relating to people, which should have informed the care being provided. For example, records showed one person at risk of malnutrition was not receiving their nutritional supplements. Staff were sending these back to the pharmacy. A letter in the person's records from the dietician gave an alternative to this supplement which should be used if needed but this was not being used.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•People were supported and encouraged to be involved in choosing and planning their own meals.
•People told us they liked the food provided and could make decisions about what they ate and drank and when. One person said, "I make my own breakfast and sometimes lunch because I'm moving into my own flat." Another said, "I like the food, [staff member name] is a really good cook."
•Staff knew people's food preferences and were knowledgeable about the extra support that some people might need. For example, where people needed their food prepared differently because of a medical need or problems with swallowing we saw this was being provided.
•People could help themselves freely to food and snacks throughout the day and night and we saw the kitchen was well stocked with tea, coffee, and soft drinks.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were not always treated with dignity and respect and involved as partners in their care. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence
•People living at the home told us staff respected their privacy and dignity. One person said, "Staff always knock on my door before they come into my bedroom."
•People's right to privacy and confidentiality was respected. People's personal records were kept secure and only accessed by authorised staff on a need to know basis. Conversations of a private nature about people were held in private and staff were careful not to be overheard.
•Some support plans contained clear information about what each person could do for themselves and staff described how they encouraged people to develop their daily living skills such as washing their clothes or tidying up.
•People were supported to keep and develop relationships with those close to them and staff recognised the importance of family.

Supporting people to express their views and be involved in making decisions about their care:
•People were happy living at Burlington Care and Support Services. One person said, "I like living here, the food is good and I have no complaints." Another said, "The staff are really kind and I know they only want what's best for me."
•People were involved in their care and encouraged to express their views and make decisions about their day to day support. Staff followed guidance and best interests decisions in this respect and understood people's rights to make unwise choices. One person said, "I talk to my keyworker about how things are going and how I am feeling."
•Staff regularly sought relative's opinions and kept them updated when things had changed. One relative said, "They are very good at letting us know how [person name] is doing, and they sent photos when she went on holiday."

Ensuring people are well treated and supported; equality and diversity:
•People were supported by staff who had a good understanding of their individual needs.
•People told us staff knew their preferences and used this knowledge to care for them in the way they liked. For instance, for one person it was important that she wore her jewellery. Staff knew this and we heard them compliment the person on their choice.
•Relatives spoke positively about the care and support people received. One relative said, "I have no concerns about the way they care for [person name]." Another said the staff are all very helpful, I have always been very happy, we have no concerns about [person name] care."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
•At the last inspection, we found people were at risk of not receiving care and support that was personalised to them because their support plans lacked sufficient detail. At this inspection we found although improvement had been made further improvements were needed.
•People did not always receive personalised care based on their preferences, interests or goals. Not all support plans were written in a person-centred way, and support was not being provided in a way that promoted people's skill development. For example, it was recorded that one person wanted to live in a flat with other people. Actions had not been taken to support this person to build the skills needed to achieve this goal.
•Staff failed to ensure people were supported to develop skills and increase their independence regardless of their level of disability. For example, staff were not supporting one person to develop their cooking skills as they felt it would not be safe for them to be in the kitchen due to their mobility. Consideration had not been given to making changes that would address the safety issues.
•Support plans did not always identify people's communication needs or how they could be supported to understand any information provided. For example, records described one person as having no communication and being reclusive. Other records showed the person could communicate and they were not reclusive.
•People were not always encouraged and supported to lead full and active lifestyles, follow their interests, and take part in social activities. For example, some people spent much of their leisure time colouring or watching television or DVDs. One person said, "I miss going out and meeting up with their friends." Staff told us this was because the person's funding had been cut or they did not have one to one support. A relative said, "[Person's name] tells me she gets bored, as there are little opportunities for her to go out."
•Some people spoke positively about their opportunities to socialise and take part in meaningful activities. One person told us when they were not volunteering at a local charity shop they enjoyed going to the gym. Another person told us they spent very little time at the home choosing to spend their time socialising with their friends.

This was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support:
•The service mainly supported younger adults and had not yet had extensive experience in supporting people towards the end of their lives. Within people support plans there was some information in relation to people's wishes about end of life care. However, the service manager recognised this was an area they needed to develop.
•There was a recognition as people got older their needs might change and the service would need to adapt

with these changes. The provider said they were booking training for staff with a local hospice.

Improving care quality in response to complaints or concerns:
•People were aware of how to make a complaint and felt able to raise concerns if something was not right. One person said, "I would speak to staff if I was unhappy," another said, "I would talk to the manager and I'm sure she will listen."
•Relatives knew who to contact if they had any concerns. One relative said; "I haven't needed to make a complaint, but I'm sure [service managers name] would listen and take action if needed."
•The provider's complaints procedure was freely available and the home kept a record of any complaints received. Records showed people's complaints were taken seriously and the home acted upon these to resolve issues.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care.
•The provider did not have sufficient oversight of the service to ensure people received the care and support they needed that promoted their wellbeing and protected them from harm.
• Burlington Care and Support Services was previously inspected in December 2016 and January 2018. At both inspections, we found breaches of regulation and the service was rated 'Requires Improvement.'
•At this inspection we found the systems and processes to monitor the service were not effective, did not drive improvement and the service manager and provider had not identified this.
•Quality assurance processes continued to be ineffective and did not identify the issues we found at this inspection. These included concerns with care records, risk management, medicines, a lack of person centred and dignified care, infection control and the cleanliness of the environment. For example, care plan audits were ineffective in identifying reviews had not taken place and that care plans did not hold accurate or complete information.
• Medicine audits did not identify unsafe practice. Environmental and infection control audits failed to identify concerns relating to the environment, furniture and fixtures or the laundry.
•Responsibilities were delegated to staff members and sufficient training or oversight was not always given. This related to care planning and environmental checks, including fire checks, and the provider failed to ensure these were being carried out in line with the regulations to maintain people's safely.
•Although the service had in place a set of policies and produces theses were not being reviewed and contained out of guidance.

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

• The provider was open and honest with us during the inspection and described the circumstances that had led to them not providing sufficient oversight.
•The provider and service manager were aware of their responsibilities under the duty of candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm.
•People and their relatives had confidence in the service manager and told us the home was well managed. One family member said, "I have no concerns about how the home is managed." Another said, "My experience has been a positive one, I have always found the manager and staff to incredibly helpful."
•Although staff demonstrated commitment to the people living in the home and told us they wanted to provide good quality care to the people living there. The provider and service manager did not act promptly when seeking specialist advice about people's changing needs.

Engaging and involving people using the service, the public and staff: Working in partnership with others:
•People, relatives and healthcare professionals were encouraged to share their views and could speak to the service manager or provider when they needed to.
•There were a variety of ways in which people could give feedback. These included annual surveys. The results of which were collated and displayed within the home. The most recent report showed the responses of people surveyed were positive. Comments included; "It's home from home," "Staff are approachable" and "Friendly environment."
•Staff told us they felt supported and valued by the provider and service manager comments included; "I feel very supported," "I have regular supervision, [service manager name] door is always open if I need a chat or want advise."
•The service was working in partnership with other organisations to support care provision and service development. Following the previous inspection, the home continued to be supported by South Devon and Torbay NHS Foundation Trust's quality assurance and improvement team (QAIT). The service manager told us they found the support helpful, although the improvements identified as necessary in the services improvement plan had not been achieved.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure each person had a care and support plan designed to achieve their preferences, including their aspirations and to ensure their needs are met. Regulation 9(1)(3)(b)

The enforcement action we took:

The Care Quality Commission have imposed a condition on your registration as a service provider in respect of the regulated activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the principles of the Mental Capacity Act 2005. Regulation 11 (1)

The enforcement action we took:

The Care Quality Commission have imposed a condition on your registration as a service provider in respect of the regulated activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way. Risks to people's health and safety had not been identified or mitigated. People were at risk of not receiving their medicines as prescribed. Medicines were not always stored securely.

Regulation 12(1)(2)(a)(b)(g)(h)

The enforcement action we took:

The Care Quality Commission have imposed a condition on your registration as a service provider in respect of the regulated activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure people receive their dietary supplements as prescribed. Regulation 14 (b)

The enforcement action we took:

The Care Quality Commission have imposed a condition on your registration as a service provider in respect of the regulated activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises were suitably maintained for the purposes for which they are being used. Regulation 15 (1)(a)(b)(c)(d)(e)

The enforcement action we took:

The Care Quality Commission have imposed a condition on your registration as a service provider in respect of the regulated activity 'Accommodation for persons who require nursing or personal care.'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service. The provider had failed to maintain accurate, complete and contemporaneous records for each person living in the home. Regulation 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

The Care Quality Commission have imposed a condition on your registration as a service provider in respect of the regulated activity 'Accommodation for persons who require nursing or personal care.'