Burlington Care Limited

Southlands

Inspection report

15 Hobman Lane
Hutton Cranswick
Humberside
YO25 9PE

Tel: 01377270271
Website: www.burlingtoncare.com

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 8, 12 and 13 July 2017. Days one and two were unannounced and we informed the manager that we would return on day three. At the last inspection in July 2015 the provider had no breaches of regulation.

We moved our planned comprehensive inspection to an earlier date because we had received concerns about some people who had lived or still lived at the service from a member of the public and from East Riding of Yorkshire Council. When we carried out our inspection we identified breaches of Regulation 9 Person Centred Care, Regulation 11 Need for consent, Regulation 12 Safe Care and Treatment, Regulation 13 Safeguarding service users from abuse and improper treatment, Regulation 17 Good Governance and Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) 2014. CQC requested an urgent action plan which was sent by the provider.

Southlands is a care home that provides accommodation and personal care for up to 48 older people who have physical disabilities and/or are living with a dementia related condition. It is a detached property set out over two floors. There were 41 people resident at the service when we inspected.

There was no registered manager employed at this service. 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. There was an interim manager in post at the time of our inspection, who had worked at the service for seven weeks, but they left shortly after the inspection. The regional manager was overseeing the service.

Risks to people had been identified but the written assessments did not reflect the practice of staff. Accidents and incidents had not always been managed in a timely fashion which had resulted in some people waiting for medical assistance, causing them distress.

Staff recruitment had not always been safe but was now more robust. There were insufficient numbers of staff on duty to meet people's needs effectively.

Servicing and maintenance of the environment had been carried out in a timely manner in most cases but one passenger lift was not working. This had been the case for a prolonged period of time and the provider confirmed this lift had been decommissioned.

Most training was completed but the learning from training had not been embedded over time into staff practice. Staff had not always been supported appropriately but since the interim manager had started in post supervisions had been reintroduced.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service supported this practice. However, staff had not followed the correct process for giving covert medicines after implementing the correct procedures in making the best interest decision.

The chef was knowledgeable about people's dietary needs and the food we saw was nutritious. They were aware of how to fortify diets and provide fortified drinks and finger foods for people living with dementia but these were not always nutritious with people eating a lot of sandwiches and biscuits. Staff were not effectively monitoring people's food and fluid intake and taking action, as required.

Staff were described by some people as being caring and we saw staff speaking politely to people in a friendly manner. However, other people told us that not all staff were caring and did not promote people's dignity or meet people's basic care needs through the care they provided. Staff practice did not always reflect what was written in in the care plans.

Activities took place but were mainly in groups and they were not meaningful to people living with dementia.

The environment was not dementia friendly and did not reflect current good practice guidance.

People knew how to make a complaint and we saw that where complaints had been made they were dealt with in line with company policy.

Notifications had not always been made to CQC in a timely manner but they are now been sent when required.

There had been a lack of effective leadership and management at the service which had led to a significant deterioration in the quality of the service. This was being addressed by the registered provider but the Commission had some serious concerns.

The quality assurance system was not effective. The issues found at the inspection had not always been identified through auditing and monitoring. The provider had an action plan which the manager was using to demonstrate where improvements were being made.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special

measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not appropriately safeguarded from unsafe care.

Risks had not always been identified and staff had not always recognised or acted when someone was at risk.

There were insufficient staff on night duty to safely meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Although staff understood the principles of the Mental capacity Act they had not always followed the correct processes..They had not implemented a best interest decision to administer a person's medicine covertly which resulted in them not receiving their medicines.

Nutritional needs were met for most people but those who required nutritious snacks did not always receive them.

The environment did not support the needs of people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

Feedback from people who used the service and relatives about staff was mixed. Some described staff as caring, friendly and helpful and others told us that some staff were kind and some were not.

Staff did not always promote people's dignity because they did not ensure that people received person centred care. When staff found behaviours difficult those people did not receive a good level of personal care. We did see some examples of good practice and some positive interactions between people and staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although care plans were detailed in most cases the risks to some people had not always been linked to the planned care and support. Staff practice did not always reflect what was written in the care plans. Evaluations and reviews were completed but care plans were not always updated following any changes in a person's condition.

Activities did take place and these were organised by a co-ordinator who worked four days a week. These were mainly group activities and there were very few one to one activities. There were no meaningful activities for those people living with dementia.

Complaints were recorded and analysed but staff were not looking at how they could prevent incidents by considering ways they could make improvements.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager at the service which is a condition of the registration for this location. There had been a lack of effective leadership and oversight at the service until an interim manager had been appointed seven weeks prior to the inspection.

Staff felt supported by managers but did not always recognise their roles and responsibilities which had resulted in some people not getting medical attention in a timely manner.

The quality monitoring system had been ineffective in identifying areas where improvements were needed.

Southlands

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.

The inspection was prompted in part by notification of incidents following which three people using the service died and another sustained a serious injury. These incidents are subject to an investigation and as a result this inspection did not examine the circumstances of the incidents.

However, the information shared with CQC (the Commission) about the incidents indicated potential concerns about the management of risks of falls and how staff responded when people became unwell and their condition deteriorated. This inspection examined those risks.

This inspection took place on 8,12 and 13 July 2017. The first two days were unannounced and we made arrangements with the manager to return on the third day.

On the 8 July 2017 the inspection team consisted of one adult social care inspector and an expert by experience. On 12 July 2017 an inspection manager and an adult social care inspector carried out the inspection. On 13 July 2017 the team consisted of an adult social care inspector, a pharmacy inspector, a specialist advisor who was a registered nurse and an expert by experience. The same expert by experience attended on two days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their expertise in this case was dementia and older people.

Prior to the inspection we had been provided with information by East Riding of Yorkshire Council about safeguarding matters relating to five people and had discussions with them about recent safeguarding concerns. We looked at all notifications we had received for the service. Statutory notifications are documents that the registered provider submits to the Commission to inform us of important events that happen in the service. We had not requested a PIR from this provider. 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.

During the inspection we spoke individually with three people who used the service. We also spoke with a group of four people and a group of three people, all of whom used the service. We also spoke with seven relatives, the cook, the domestic, the activities co-ordinator, the manager, the regional manager and one of the directors. We interviewed four care workers and the deputy manager. We 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 inspected how medicines were managed for seven people, observed activities and observed the lunch time period in the dining room, lounges and people's bedrooms. We reviewed four care plans in detail and looked at a further seven to gather information about specific issues. We also reviewed meeting minutes, maintenance and service records and audits carried out at the service. We inspected eight recruitment records including the training records for these staff. We received a copy of an up to date training matrix for all staff and the staffing rotas from 3 April – 9 July 2017.

Following the inspection we asked the provider to send us details of trainers and their qualifications and accreditation, training course content and an up to date statement of purpose. These were sent to us in the week following the inspection.

Inadequate

Is the service safe?

Our findings

We inspected this service because of the number of concerns raised with East Riding of Yorkshire Council (ERYC) about people's safety. These are called safeguarding alerts and had been made to ERYC, because they have responsibility for investigating any matters relating to safeguarding adults in this area. We also received information of concern from a relative. The information raised potential concerns about how people's care was managed. We looked at these issues during the inspection and found further concerns around people's care and safety. There had been 20 safeguarding notifications made to the Commission between April 2017 and the date of this inspection.

The information we received prior to the inspection identified there may be issues in the following areas: inadequate risk assessment and care planning, lack of personalised care, unsafe care, people not safeguarded, documentation not being completed correctly, staffing levels not adequate and concerns regarding the leadership of the service. ERYC had recently been visiting people at the service weekly. In addition, district nurses, who had patients at this service had been visiting regularly to ensure their well-being.

Two of the three days of inspection were out of normal working hours because we understood from information we received that there may be potential issues at these times and at the inspection we found this was the case. It was necessary for us to make four individual safeguarding referrals to ERYC following the inspection.

Appropriate safeguarding policies were in place for the service. These policies were in place to ensure the correct management of any allegations of abuse. Although all staff had received training in safeguarding adults during the last three years in line with company policy, only sixteen staff had completed any training in the last twelve months. When we spoke with staff they were able to tell us that they would report any incidents to a senior member of staff. However, some of the incidents we had been notified of were highlighted by visiting professionals to the service because staff had not recognised the need to alert the local authority. This meant that some people were not safeguarded by staff at this service because they had not identified or alerted the appropriate authorities with details of incidents or concerns.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment.

When asked if they felt safe living at the service people made comments such as, "Yes, people are pretty good to you" and "The carer is a nice fellow." Other comments included, "Yes, safe room and staff" and, "I don't know any (Service user) that isn't (safe)" and, "I feel safe, staff are normal people, we know them."

Relatives also made comments about safety saying, "[Relative] wouldn't be here if she wasn't (safe)" and, "Yes, [relative] has got a bell for staff and usually people looking in." Another gave examples to explain why they felt their relation was safe, including, "Always carers around, locked doors, has a pressure floor alarm mat; never on their own."

Risks to individuals had not been adequately assessed and risk management plans were not always in place. The care we observed did not always correspond with what was recorded. This meant people were at risk of avoidable harm because staff were not following the recorded plans for people. For example, assessments had been carried out using a recognised malnutrition universal screening tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. For one person, we saw that there were gaps when the MUST screening tool was completed. The person's care plan stated, "To be weighed monthly and their weight recorded according to the MUST tool." This had not been done consistently and there were only four weights recorded between 1 December 2016 and 13 July 2017.

Risk assessments to identify the risk of skin damage had been inconsistently completed. One person was assessed as being at high risk of skin damage but their record was not reviewed between March and June 2017. A second person had a care plan review in June 2017 which referred to sore areas on their body. We saw that they required a cream to be applied but this had only been applied once according to charts we saw in the person's bedroom. We were told that the person still had sore areas when we carried out our inspection but staff had not sought assistance from district nurses to manage this condition. The lack of consistency in care provided for people put them at risk of deterioration in their health and well-being.

There had been 31 accidents and incidents in May 2017 and 11 in June 2017. These had been analysed and trends identified but there were no clear actions identified from the data. For example eighteen incidents in May had occurred during the afternoon and seven at night. There was no evidence that the provider had looked at staffing at those times or considered other factors to try and prevent further incidents.

Servicing and maintenance checks of the premises had been completed in house and by external contractors. These were recorded. Fire safety checks had been completed but staff did not take measures to ensure the environment was a safe as possible. There were boxes of paper stacked outside a lift that was out of order but in a public thoroughfare near a staircase; this was a fire hazard. We asked the manager why the boxes were stacked there. They told us they had been left there when people's personal information had been removed from their files for archiving and had been there for three weeks. In addition people who used the service did not all have individual personal emergency evacuation plan in their care plan. It is considered good practice to have these completed for people who have a disability to ensure their safe evacuation. Staff had already told us they had no time to look at care plans and would not necessarily have been aware of people's needs through other means. We saw from records that not all staff were trained in fire safety. We have notified the Humberside fire and rescue service of our concerns.

Servicing of mains services had taken place within the last 12 months. The passenger lift which people were using to get upstairs had last been serviced on 1 November 2016 and the hoists and slings on 9 December 2016.This was not in line with HSE guidance says that lifting equipment is required to be checked every six months. There was one lift out of action which a senior care worker told us had not been working for a few weeks. However, when we spoke with another member of staff they said the lift had not been working for around four years. The provider confirmed this lift had been decommissioned some years ago. There was an emergency plan for the service in place which guided staff about what to do in the event of an unexpected event such as loss of electricity or flooding.

Medicines were stored securely and access was restricted to authorised staff. Controlled drugs (CD's) which are medicines that require extra checks and special storage arrangements because of their potential for misuse were stored in a controlled drugs cupboard. Access to them was restricted and the keys held securely. We saw evidence of regular balance checks of controlled drugs.

We checked medicines which required refrigeration and found they had been moved into a domestic

refrigerator in the kitchen due to a failure of the medicines refrigerator. Staff had recorded the kitchen thermometer was not working and temperatures outside of the recommended range had been recorded on seven occasions in June 2017 and one in July 2017. This had not been risk assessed and we could not be sure these medicines were safe to use.

All service users had photographs and allergy details completed on their medicine administration record (MAR); this helps to prevent medicines being given to the wrong person or to a person with an allergy. We checked records for two people who were prescribed blood thinners and saw there were appropriate systems in place to ensure the right dose was administered.

Some people were prescribed medicines to be taken when required, or 'PRN'. We found there was a lack of supporting information to guide staff how to administer these medicines safely. In addition, staff did not always record the reasons for giving when required medicines or the outcome after giving them.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. Topical MARs were in place to record the application of these medicines; these had not always been signed by care staff when they had applied creams. Body maps were not in place to guide staff where to apply creams and topical MARs did not always contain this information.

We found people did not always receive their medicines as they had been prescribed. For example, one person's medicines were to be administered covertly (disguised in food or drink). Appropriate assessments had been carried out in accordance with the Mental Capacity Act and the decision to administer medicines covertly in the person's best interest had been recorded in the person's care plan and in a medicines risk assessment. Despite this, the person had not received two of their prescribed medicines on 19 occasions between 23 June 2017 and 13 July 2017, and one of their prescribed medicines on 21 occasions between 23 June 2016 and 13 July 2017. Care staff had recorded the person had refused their medicines and had not acted to follow this up adequately with the person's GP. This meant there was a significant risk to the person's health and welfare. We raised our concerns with the home manager who assured us this would be followed up with the person's GP.

We found two further people who were prescribed preventer inhalers to be used regularly had received no doses between 23 June 2017 and 13 July 2017. In one case the inhaler was still sealed and had not been opened. This meant there was a risk of harm from deterioration in breathing. We contacted one person's GP and we were assured the person would be reviewed at the earliest opportunity.

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

We checked communal areas and people's bedrooms and found that they were clean and tidy. There was a team of domestic staff who followed cleaning schedules to ensure the service was cleaned on a regular basis.

The service did not have sufficient numbers of suitably qualified, competent and skilled staff to meet people's needs. We identified gaps in the staff rota between April 3 and July 8 2017 which showed the service had not met their own identified minimum staffing levels to enable them to deliver safe care. Out of the 41 people who used the service eight required two people to move them and provide personal care. Two people were receiving end of life care and 23 people lacked capacity, had cognitive impairment and/ or had behaviours that challenged staff. At least two people were at high risk of physical aggression towards others. The size and layout of the building meant that people did not have access to adequate levels of staff

overnight which put them at risk of not receiving the care they required.

We asked people whether they thought there were enough staff on duty and they told us, "Sometimes there is a long wait, but no more than 15 minutes" and, "Could do with a couple more (staff)." One person told us, "Sometimes short staffed and do not get chance for a chat" and a relative said, "Last week, during the night a carer came in and turned the call bell off. They said they would be back but never did (return). When I asked [name] why they called they couldn't remember."

Relatives told us when asked about their relative going out, "There are not enough staff to take them so a member of staff is taking her in their own time." Other relatives said, "At times not enough; recently there has been improvement" and another said they had visited and [relative] had been wet and they had to ask for them to be changed. They commented that this had not happened in recent weeks but said, "[Relative] says there has been a bit of a wait at weekends." Another relative told us the impact of the staffing levels had been, "Nails need cleaning and towels not in [relative's] bathroom," although they said this had recently improved.

When we spoke with staff one care worker could not tell us what people's specific needs were because they said, "There are not enough staff especially at night" and "I have no time to read care plans. I have a rough idea what's in them." Another member of staff told us, "During the day it's OK but only three at night which is not enough." They also said, "I've read a few (care plans) but there are that many!" One care worker told us that the consistency of the service that people received was dependent on staffing levels. They told us, "All day is short (of staff); 4pm is a bad time. I think it's very low (staffing levels) and it is a struggle. Staff are tired doing so many hours." We saw that night staff had highlighted their concerns about there being no senior at night in staff meeting minutes dated 4 May 2017. They were told that 'There is to be no senior any time soon'. Rotas confirmed that staffing levels varied and although there had recently been four night staff for a few weeks between May and June 2017 this had now returned to most nights been covered by only three staff. We discussed this with the manager, regional manager and provider who told us they were currently recruiting for night staff as they had identified that four staff were required.

Each person had a dependency assessment completed in order to determine how many staff were required to work on each day. These assessments identified whether people's needs were low, medium or high and gave a score. Four people had needs assessments which were not an accurate reflection of their needs. For example one person we saw had behaviour that challenged and had no score for 'challenging' recorded on the dependency assessment. The scores were incorrect which led to their level of need being incorrectly assessed. Although we could see that there were some people with complex needs only one person had been assessed as having high needs. The inspector and the registered nurse checked four dependency assessments which were all completed incorrectly according to details we used from care plans and our own observations. At least one person would have moved into the range of high needs following the reassessments.

We asked to be shown the content of first aid and safeguarding courses and saw that a six hour emergency first aid at work course had been completed by seven staff. The emergency first aid at work course was required to be repeated every three years according to the training matrix supplied by the service. However, the Health and Safety executive (HSE) recommends that this training is updated annually. We saw no evidence that this had been done and only three people had received any training within the last year. The deputy manager told us that there was a first aider on each shift when we spoke with them on 12 July 2017 but we identified from rotas that this was not the case. This meant that the provider had not considered the risk to people by not having a first aider on the premises at all time which put people at risk of harm.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

We made the manager, who was acting on behalf of the registered provider, aware of the multiple concerns we had during the course of our inspection. We also wrote to the provider to make them aware of our immediate concerns.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us they thought staff knew what they were doing. One person who used the service told us,"I think they do but I am not an expert "and a relative told us,"A lady here has had a [medical condition] and they look after her really well."

A member of staff said, "Some members of staff are not competent" and another told us, "We do our almost best." When we asked what that meant they said they could not do their best as they did not have the time. Our own observations highlighted some lack of skilled practice with staff not always recognising poor practice. We identified a number of factors contributing to this situation. There had been a lack of leadership of the staff team and a lack of up to date training and competency checks until recently which meant that training was not embedded in every day practice.

People received an induction when they started working at the service. They spent three days away from the service completing induction training and then came into the service to carry out shadowing shifts. We saw that the newest member of night staff had been identified as shadowing on the rota when they started and was supernumerary. The induction consisted of some basic training including moving people and first aid. One member of staff who told us they had attended an accredited course in the past said that the first aid training was, "very basic." Another member of staff said, "The training was adequate" and told us there had been more training recently.

People did not have a wide range of training certificates in their individual files to evidence any training they may have completed. The training matrix showed that staff had completed training but some was not completed recently. However, the service had identified that the frequency of training for each subject was between two and three years. The induction, fire safety, moving and handling, dementia awareness, safeguarding, health and safety and infection control were considered to be mandatory training for all staff but only 78% of staff had completed their induction and fire safety training.

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 authorisation 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

People's plans of care showed the principles of the MCA Code of Practice had been used when assessing their ability to make some decisions. The service also had a policy and procedure on the MCA and DoLS to

protect people. However, staff did not fully understand the principles of the MCA and DoLS because they were not always following the best interest decisions that had been made. Best interest decisions are made when someone does not have the mental capacity to decide on their care and treatment. These should include family, friends and relevant professionals in order to find the best outcome for a person. The service had followed this process for one person and it had been agreed they could receive their medicines covertly. However, when the person who was living with dementia had refused their medicines staff had not given them covertly.

When we spoke to staff about this they said that the person refused their medicines so they had not given it, demonstrating a lack of understanding of the legislation and the covert medicine plan. This meant that the person was not taking their medicine as prescribed which meant there was a significant risk to the person's health and welfare.

There was little evidence of consent or approval by appropriate representatives in respect of all care and treatment. One person who held lasting power of attorney for their relative said they had not been informed on one occasion when the person had fallen. They complained to the manager about this.

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

The manager told us they had applied for a number of DoLS authorisations, and some had been granted. Other applications had not yet been assessed by East riding of Yorkshire Council. Records confirmed these had been applied for and the decisions had been made in the person's best interests.

Where appropriate, Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) were correctly completed with the relevant signatures.

People's nutritional need s were met to some degree but those people living with dementia were not receiving nutritious finger foods and high calorie snacks when it had been identified as a need in their care plans. Staff gave out biscuits and puddings which were beneficial in preventing weight loss but provided no nutritional value. We spoke with the cook who was new to the role but not to the service. They had previously been a care worker so knew people and their likes and dislikes. Some people required their food to be pureed or soft and the cook had identified who had textured diets on a whiteboard in the kitchen. They told us of the need to fortify people's food and told us they provided milk shakes for people and fortified foods with where appropriate. We did not see milk shakes been given throughout the three days of inspection.

In the dining room we did not see menus for people to choose what they wanted to eat but we did see a member of staff asking people what they would like to eat for lunch in the morning and a list of their choices was displayed in the serving area as a reminder for staff. This system meant that people living with dementia would not always remember what choice they had made by lunch time. Visual aids, such as pictorial menus or examples of what food is on offer help people to make choices at the time of the meal.

Tables were set with napkins and cruets and there were small vases of flowers. Three people had chosen to eat their meal in a different room. Some people ate their meals in their rooms and their trays of food were covered. The food looked hot and appetising and people enjoyed the food. One person told us, "[Food] is quite good, I enjoy it" and another said, "Food is excellent, it's served hot, always have a choice. Chocolate cake yesterday was excellent." A third person said, "I have been having sandwiches for dinner and tea as I struggle to use a knife and fork. Staff are going to assist me with all meals."

Relatives told us, "Food seems okay. I ask for it to be cut up and for some assistance (for relative)"; "She says it is basic. There is enough I think and there are drinks about" and "She says food in general okay, a lot of sandwiches."

One member of staff sat by a person's side and assisted them to eat. This was done appropriately but there was no conversation. When they had finished another person sat at the table and the member of staff also assisted them but again there was no conversation. The care worker did not display the skills necessary to communicate with people who were living with dementia.

Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. The food charts recorded the food a person was taking each day and included portion sizes. However, they were inconsistently completed and often did not record what people ate after afternoon tea. For one person we saw no record of any extra snacks being given.

Fluid intake charts did not consistently record the fluid a person was taking each day and fluid intake goals and totals were not recorded. This meant staff were not effectively monitoring people's intake and taking action, as required.

We recommend that the provider considers and implements best practice in relation to nutrition and fluid requirements of people living with dementia.

The environment did not support the needs of people living with dementia and did not support good practice. The standard of bedrooms varied from personalised to bare and uninteresting. The service was based on a square with continuous corridors on the first floor so people could walk unhindered. On the ground floor this was not the case. However, the floor changed levels in places on the first floor and because the flooring was continuous it was not easily recognisable so was a trip hazard.

There was a colour contrasting handrail but no other use of colour to identify places or aid people in finding their way around. Bedroom doors and corridor walls were not distinguishable from each other for people with visual or cognitive impairment except by a number on each door. Contrasting colours had not been used in order to highlight important areas. For instance contrasting coloured toilet doors and seats can aid people's orientation to the toilet and support their continence needs. There were no customised signs to identify the person's room using names and photographs or personal objects. This was not helpful in retaining people's independence in finding their own way around the building.

Disorientation and bewilderment are a common experience for people with dementia. Signs can be very helpful if they are clear, mounted low enough, have words and a picture and contrast with the background.

There were some tactile pictures on the walls but no themed areas around the building to provide topics of conversation for people and no rummage boxes or identified drawers that people could open and explore. A rummage box is container filled with familiar items as a means of reminiscence. It helps people with dementia feel secure in familiarity and can be used as an activity, as a distraction technique and therapeutically as a reminiscence tool

The service had beautiful grounds and gardens but these were only accessible for people living with dementia if accompanied by staff as they were not secure. Gardens and outdoor spaces which have fences or other physical boundaries help people to avoid accidentally leaving safe areas and being exposed to risks. This service was situated just off a very busy main road which posed a risk for people.

The gardens had not been adapted for people with dementia. For instance there were no well-defined paths to help people to find their way around. Research evidence suggests that free-flowing looped designs are preferred.
There was an inner courtyard and we did see people sat there.

We recommend that the provider research dementia friendly environments and consider ways to implement these principles in the home. .

Medical conditions which required monitoring were managed in consultation with people's GPs or the community mental health team. There was a written staff handover between shifts which had been introduced recently so that staff were aware of any changes in people's care needs and whether there was any information to share from health care professionals. This had not always been completed in a robust way. GP and other health care professionals visits were clearly recorded which meant that communications around people's health were easy to monitor. However, instructions from professionals had not always been followed by staff. For example in April 2017 we saw that one person's care plan referred to, "falls team have supplied [Name of person] with leg strengthening exercises to be completed twice daily." There was no record that these had been discontinued and we did not see these being carried out or any records that showed they had been done.

We saw from people's records that they had attended appointments at hospital and some were visited in the service by healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

One person who used the service described staff as "Nice; if you are alright with them they are alright with you" and, "They are caring, but they are also efficient." A relative told us, "I am really happy about this place. Staff are good and all friendly and helpful; that is what matters." However, we saw that the quality of care and support provided to people was task orientated. For instance people cared for in their rooms were left socially isolated unless there was a task such as eating or personal care that required staff to attend. People in the communal areas had staff chatting to them throughout the day as they passed but there was limited meaningful engagement with people as staff were constantly busy.

Staff did not always promote people's dignity because they were not thoughtful about the care they provided. We saw that one person who was living with dementia was left sat in their wheelchair all day and only received personal care once in a ten hour period. This was because their behaviour challenged staff and they did not seem clear about how to respond to the person. On the first day of the inspection they looked unkempt, had not been shaved, their eyes were sticky and they had dried food around their mouth. They slept for most of the day.

We saw copies of bath water temperature checks in a first floor bathroom which indicated that only sixteen baths had been completed since 9 May 2017. These were checks completed each time someone had a bath. Some of these were for the same people. We went to check other bathrooms on the first floor but found that the only other bathroom was not in use. When we explored this with the manager they said people would have been bathed in the second bathroom. When we pointed out only one bathroom was in use they could not explain why there were so few temperature checks but told us that everyone was bathed regularly. We checked for one person who appeared not to have had a bath since 9 May 2017. We saw that they had received baths since then but had on one occasion not had a bath for two weeks. There was no reason given for this. This did not support their dignity and well-being. A person's appearance is integral to their self-respect and older people need to receive appropriate levels of support to maintain the standards they are used to.

On day two of the inspection one person was very vocal and pushed themselves around the service in a wheelchair without any staff interaction. They had difficulties with communicating verbally and staff did not try and spend time understanding what they might want but instead left them to shout out. When staff asked them questions such as 'what would you like to eat?' they did not give the person time to respond which was a trigger for them to shout more and become aggressive towards staff. This showed a lack of understanding of the person's mental health condition.

Another person called out throughout the day. On one occasion we heard them calling, "Nurse" and saw a care worker walking down the corridor towards the shouting. We then saw the care worker turn into another room and ignore the calling initially. They reappeared after a few minutes and went to see what the person wanted. We saw that staff spoke to this person in passing but were too busy to have a meaningful conversation with them. This person was often the subject of verbal attacks by other people who used the service because of them shouting. They were encouraged by staff to sit away from other people who told us

this was for their protection, but this left them socially isolated.

We saw one person tell a member of staff they were worried and needed to go to the toilet and the care worker walked away. This person's care plan said they would ask when they needed to go to the toilet. The member of staff showed no concern for this person's predicament and demonstrated a lack of care by not meeting their immediate needs.

Feedback from relatives was mixed which showed some inconsistency in care practices. One relative told us, "[Relative] says some are kind and some aren't, says they are rushed and don't have a lot of time," but another told us, "When they pass her they give her a kiss, make a fuss."

We saw one member of staff demonstrate some elements of good practice when assisting someone to eat and drink because they were discreet, sat with them and did not rush them. They concentrated solely on the person, showing them respect. However, they did not communicate which may not have made this a pleasant dining experience for the person and did not give the person opportunities to say how they might like to be assisted.

We saw that staff convenience and routines took preference over people's routines and wishes which did not take account of people's diverse needs. In the staff office we saw a list of seven people with a note saying that night staff should get them washed and dressed before they went off duty. One member of staff told us that there was no good reason to get some people up and at times they were still sleeping and had to be woken. We checked the sleep care plans for these people and saw that there was no need or preference to wake four of the seven people.

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

We did see some positive interactions in the communal areas with staff speaking to people in a kind manner. We saw one member of staff sat chatting to three people in the dining room and one member of staff knelt beside a person to find out how they could help them.

Staff did respect people's privacy. When we visited one person in their bedroom staff knocked on the door and waited before entering. They also left unopened post for the person in their bedroom. A relative told us, "As far as I know they draw curtains and close doors (when providing personal care)."

We did not identify anyone with an advocate but one person had one to one support because they were at risk. This type of support allowed them to remain safe at the service.

There were two people receiving end of life care when we carried out this inspection and we saw that for one person there was an advanced care plan in place. This had been compiled with the person and their relative and contained details of their wishes for their care and after death. This person had anticipatory medicines prescribed and in place. These are a small supply of medicines that can be kept at the service just in case the person needs them to treat any distressing symptom they may experience. None of the staff at this service had received training in end of life care but they were supported by the district nursing staff.

Confidentiality was not always respected. Peoples private information was not kept in a secure place so that anyone could have accessed documents.

Requires Improvement

Is the service responsive?

Our findings

Care planning documentation was not consistent and did not always reflect the care that was being provided to people. The care plans were detailed and but there was not always clear association between risk and planned support which is good practice and observed practice did not always reflect what was identified in the care plans. We saw no evidence that people or their representatives had been involved in planning their care but one relative told us they had input when their relative first came to the service.

People's care needs were not always identified promptly. For example, one person's independent lifestyle plan said they could independently use the bathroom. Following an accident three months prior to the inspection this person's mobility needs had changed and this was only identified in the continence care plan. The mobility care plan said that the person was at high risk of falls and had a shuffling gait but did not give staff specific instructions on how to manage that person's mobility whilst encouraging independence. This confusion led to the care plan being unclear which could have an impact on the person's safety and staff practice.

Communication care plans were in place but only gave limited information for staff to follow in relation to how they engaged with people. This approach meant staff did not have all the information they needed to provide responsive care and did not recognise that people with communication needs could still be engaged in interaction. One person had difficulty with verbal communication, was deaf and had poor eyesight but there were no detailed instructions for staff about how this should be managed alongside their dementia. We saw examples where staff just spoke loudly to ask questions but did not use touch or other ways of communicating to let the person know they were there. This meant that people were unable to communicate in a positive way because staff were not aware of or using all the tools available to them to ensure the person's voice was heard.

One person took a particular medicine which required them to have similar amounts of fluid each day. The care plan identified they needed fluids to be accessible but did not identify the daily amount recommended by the GP. This information was not known by all staff and was not recorded in the care plan. When we checked the persons fluid charts we saw that on most days they were drinking the correct amount of fluid but on one day had doubled the amount they should have. The care plan did not reflect the specific details of this persons fluid needs and staff were not aware which put the person at risk.

People's care plans in relation to their behaviour management were not always personalised and specific. They did not show how symptoms of different types of dementia presented and did not detail the exact support staff should provide to manage those symptoms. Following any behavioural incidents there was not clear indication of what monitoring was required and who staff should contact for additional support if needed. There was no information on why the person may demonstrate these behaviours such as pain, being unwell, being over stimulated or having a low mood. Staff were not directed to offer support to resolve the problem by offering the person time, using verbal and nonverbal cues to communicate and to show they were listening to the person. Basic guidance was provided for staff but more detailed plans were not available to enable them to manage situations in a consistent and positive way, which protected people's

dignity and rights.

One person's care plan identified that they needed support to change position every two hours as they were at risk of damage to their skin. We saw they only changed position once in ten hours.

There was a clear plan for staff to follow in the event that one person had any falls. However, staff had not followed this plan resulting in a delay in seeking treatment from a healthcare professional.

We did not that some care plans had been evaluated monthly and were reflective of people's changing needs.

No activities took place on the first day of our inspection which was a Saturday. There was a weekly activity board but apart from bingo on the Friday and a movie on Sunday nothing else was listed. We did not see any activities taking place on day two as we visited in the evening but on day three of the inspection we saw people join a group for singing which they enjoyed. We did not see any one to one activities take place. People cared for in bedrooms were socially isolated. Quality statement 4 in The National Institute for Health and Care Excellence (NICE) guidance QS30 states that there should be, "Evidence of local arrangements to find out about the individual interests and preferences of people with dementia in order to ensure access to leisure activities of interest and evidence of local arrangements to ensure that people with dementia are enabled to take part in leisure activities during their day based on individual interest and choice." We did not see any evidence that the life map or social activities care plan had been used to effectively identify activity for people.

There were no obvious meaningful activities. People did not take part in tasks around their home. Being engaged in meaningful activity allows some of people's most basic needs, such as socialisation, a sense of accomplishment, a sense of purpose, play as well as a need for cognitive and physical stimulation to be met. There were no rummage boxes or items to stimulate conversation. We did not see any newspapers in the lounges or people's rooms.

People's feedback about activities was varied. One person told us, "We play Bingo and get some nice singers in" and another said, "I like reading, I watch TV and go for a walk." A third person said, "I sat out in the garden yesterday and hope to today." One person said, "Not really a lot of activities." A relative told us, "None as far as I know" and a second said," None, I wish she (relative) could but she can't." One person said they enjoyed tennis and we saw that tennis was on the television but the sound had been turned down so people could not hear the commentary.

People knew how to raise concerns or complaints. They told us they would speak with a member of staff or the manager. One person said, "I would go to the manager but if not satisfied I would take it further" and another person said, "Go to the top if you can work out who is in charge each day." We reviewed the complaints record and saw that 23 complaints had been recorded since the last inspection. They were related to concerns from relatives about people's care and welfare. These were investigated and responded to appropriately in line with company policy.

Inadequate

Is the service well-led?

Our findings

Southlands is one of thirteen services run by Burlington Care Limited. The registered provider had seven services rated good, two requiring improvement and four services that have not yet been rated.

The registered manager for this service had recently left in April 2017 and there was an interim manager at the service when we visited. They have since left the service. At the time of our inspection they had been at the service for seven weeks. The registered provider had started to recruit for a new and suitable manager to take the service forward.

The regional manager was overseeing the service and was present for the inspection. There had been a lot of changes within the staff team and it was proving difficult to recruit staff to the service which meant the service was heavily reliant on existing staff and some shifts had not been covered.

There had been a lack of effective leadership and management oversight at the service which the registered provider had identified before the inspection. The manager told us at the beginning of the inspection that that they were working hard to make the necessary improvements. There had been a high number of safeguarding alerts made to the local authority since April 2016 and the manager had been working with the local authority and other professionals to make improvements in this area.

Generally staff felt supported. However they did not recognise their roles and responsibilities which had resulted in some people not receiving care and attention in a timely manner. Some people had been identified by the safeguarding team over the last year as having had to wait for medical attention which had resulted in them suffering pain and distress. These cases are the subject of a separate investigation and as such have not been discussed in this report.

There was a quality assurance system in place but a lot of the issues we raised had not been identified in audits completed by the service. Managers had not monitored the standard of care that people had been receiving until recently. This meant that the audits and oversight of the service was not robust. This had resulted in a situation where some areas of the service, such as the development of paperwork, had shown improvement but the basic care of people had deteriorated and placed people at risk.

Accidents and incidents were being recorded in both daily notes and in a central monitoring system. Although we saw that the incidents were analysed and trends identified we did not see any actions to prevent reoccurrence. Even where measures had been put in place to address any issues staff did not always follow them. For example where one person had a clear plan following any falls staff had not followed directions. We spoke to the staff member who told us that they were unaware of the steps to take. Therefore, risks related to accidents and incidents were not being adequately assessed or managed and meant people remained at risk of harm. In addition the provider was not making sure that new processes were understood and followed diligently by staff resulting in risk to people. For example, the manager had implemented fluid charts but staff were using different documents and not completing either document regularly. They were not clear which one should be used.

The risks relating to the health, safety and welfare of people who used the service and others who may be at risk had not been acted upon. For example, one person's care was not being well managed by staff but no advice or support had been sought by managers. The person's health had deteriorated but because their behaviour challenged staff they had not received adequate care and support. No request for a reassessment of the person's needs had been requested by the manager.

Notifications to CQC had not always been made in a timely manner although this was now been addressed by the regional manager. Previous incidents had been notified following a delay in some cases. In addition after visiting social and healthcare professionals assessed people at the service they had notified us of some events that had not been identified by the manager. More recently the service was not notifying incidents more proactively although they had not identified the four incidents that we had alerted the local authority about.

The registered provider had failed to ensure that they were meeting all the Regulations.

This was a breach of Regulation 17 of the Health and Social Care act 2008 (Regulated Activities) 2014- Good Governance

Culture reflects the shared values of a service. The Burlington Care company website says, "At Burlington Care our mission is to provide our residents with a happy quality of life, exercising maximum independence, autonomy through choice and fulfilment, quietly and discreetly ensuring they are looked after in every way, in a warm and safe environment." However, this was not what we found at the inspection. Staff and professionals gave us their feedback and our own observations were inconsistent with what the provider was saying in this statement. A member of staff told us, "I wouldn't say people always get supported in the way they want" and another said, "I think the company is getting too big. We saw the owners more when it was smaller." Staff were not provided with sufficient direction and leadership to ensure that people received a consistently good standard of care.

This meant that care and treatment at the service was not delivered consistently or safely and people living at the service were at risk of harm which could have been avoided if the registered provider had taken the action required of them to mitigate these risks

The registered provider's representatives responded promptly when we wrote to urgently share our findings and concerns. They took immediate steps to act on our findings. They were clear that improvements at the service were needed but that changes within the service would take time. They made some immediate changes following our initial feedback to ensure people's safety and sent us an urgent action plan to tell us what they would be doing to address other areas of concern.