Burlington Nursing Home Limited

Burlington Nursing Home

Inspection report

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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 was an unannounced inspection that took place on the 11 July 2018. We also returned to complete a second day of inspection on the 13 July 2018 which was announced.

We previously inspected the service on the 29 June and 3 July 2017 at which time the service was rated as 'Requires improvement'. There was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was also inspected on the 4 and 5 October 2016 at which time the 'Safe' key question was rated as 'Inadequate' with an overall service rating of 'Requires improvement.'

Following the last inspection in 2017, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions rating to at least 'Good.' At this inspection we found that inadequate progress had been made and the previous breach of Regulation was repeated. We also found further breaches of Regulation at this inspection. 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.

Following this inspection, we received an action plan from the registered manager. This demonstrated that they had begun to address the shortfalls identified at the service. We will review this at the next inspection.

Burlington Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Burlington Nursing Home accommodates a maximum of 40 people in one adapted building. At the time of this inspection 32 people were living at the home, one of who was in hospital. Most people who lived at the service were living with dementia. 23 people received a service to support a nursing level of need, while nine people received a service to support a residential assessed level of need.

There was a registered manager in place. 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.

We found significant concerns regarding the safety of the service provided to people. Maintenance checks for lifting equipment as required in law were not completed. This placed people at serious risk of harm occurring. Environmental risks were not safely assessed or managed for people.

Medicines were not always managed safely for people and staff were not suitably trained and competencies had not been completed to demonstrate that staff were able to give medicines safely to people. The use of 'covert' medication was not understood by relevant staff. One person was in receipt of covert medication at the time of this inspection. Unsafe and illegal medicines practice of one nurse who 'borrowed' medicines from one person to give to another were seen.

Staff did not receive regular supervision or appraisals in their roles.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not fully understood by staff at the service.

Regular staff were caring and treated people with respect. One nurse said, "I enjoy it", "lovely team" and that working at the home was "like working with a family." Although agency staff used did not always give people a caring service.

Confidentiality was not always maintained with records not stored in accordance with Data Protection legislation and policies had not been updated to reflect the changes to Data Protection law.

People's needs were not always reviewed when their needs changed and records were seen to be out of date and not reflecting people's current needs which placed them at risk of not receiving the care they needed when agency staff were used. People were not always offered choice of foods to meet their individual needs and preferences. We saw that regular staff interacted positively with people during meal times and took time to support people sensitively without rushing them.

People and their representatives were not always involved in the care planning and decisions about people's care.

The complaints process was not always accessible for people or their representatives. This was an area that required improvement.

End of life care was received by people at the home and the registered manager had completed accredited end of life training. Systems regarding how staff were informed of people's end of life and resuscitation required improvement.

The home was not well-led. Systems had not identified when there were significant risks to people's safety.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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.

Equipment was not safely maintained which placed people at risk of significant harm.

Environmental risks to people were not always assessed or responded to safely.

Medicines were not always managed safely.

Measures were in place for infection control.

Lessons were not learned following previous inspection report outcomes.

Is the service effective?

Requires Improvement

The service was not always Effective.

People's care plans did not always reflect positive outcomes for people in line with their protected characteristics.

Staff were not always well trained and did not understand the principles of the Mental Capacity Act 2005. Staff did not receive appropriate supervision in their roles.

People were supported to eat and drink enough. However, there was limited choice at meal times for people.

People had access to healthcare.

Is the service caring?

Requires Improvement

The service was not always Caring.

Confidentiality was not always maintained for peoples records and up to date Data Protection policies were not in place.

People's individuality was not always respected in records for people.

Use of agency staff had not always been a positive experience with a lack of dignity and compassion. Staff who knew people well provided a caring and compassionate service.

Some people had been supported to maintain a level of independence.

Is the service responsive?

Requires Improvement

The service was not always Responsive.

People's needs were not always reviewed consistently and records were not always updated to reflect changes to people's needs. People and/or their representatives were not adequately involved in the planning and decisions about their care.

The complaints process was not accessible for people who used the service who may have been living with dementia and other disability.

People had been supported to engage in meaningful activities that were positive experiences for them. People had been supported to access the wider local community.

People were supported at the end of their lives. Systems within the home required improvement regarding this.

Is the service well-led?

Inadequate

The service was not Well-led.

Systems and process were not adequate and did not ensure that the service was safe for people. The quality of the service was not adequately monitored.

The registered manager did not always understand their role and responsibilities at the service.

Despite previous CQC inspection reports that were rated as 'Requires improvement' the service had not improved the quality or safety of the service to an adequate standard.

Burlington Nursing Home

Detailed findings

Background to this inspection

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

We inspected the service to review the previous breach of Regulation and 'Requires improvement' rating to establish if sufficient progress and improvements had been made to the service.

Before this inspection we reviewed information that we held about the service. This included information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the notifications the provider had sent to us following specific incidents that had occurred which included medicines errors for people.

This inspection took place on 11 July 2018 and was unannounced. A second day of inspection was conducted on the 13 July 2018 which was announced.

The inspection was completed by one inspector and one specialist nurse advisor with knowledge and expertise about the systems and processes required within a nursing home setting.

We spoke to three people. Some people were not able to tell us about their views of the service because they were living with dementia. 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. In addition to speaking with three people, we also observed the experiences of three other people. We spoke to one relative of a person who lived at the home.

We spoke with ten members of staff including the registered manager, deputy manager, registered provider, two trained nurses, an activities coordinator, the cook, a housekeeper, and two care staff. We spoke with external health and social care professionals, including a community matron, community dietician, two paramedic practitioners, a GP, an independent advocate and a social services team manager. We reviewed

the records for four service users including care plans, risk assessments, maintenance records and medicines management records. We also looked at six staff recruitment, training and supervision records.

Inadequate

Is the service safe?

Our findings

At the previous inspection in 2016, we found that risks to people were not adequately assessed or mitigated which resulted in the 'Safe' key question of the report being rated as 'Inadequate.' At the following inspection in 2017 some improvements had been made and the 'Safe' section of the report was rated as 'Requires improvement.'

At this inspection we found that improvements had not been sustained and risks to people were not adequately managed.

People were placed at risk of significant harm due to unsafe practices. Systems had failed to identify that equipment used to support people to move had not been maintained safely. Bath hoists, moving and handling hoists and slings had not been serviced or checked for their safe use within the timescales required in law. Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) state that hoist equipment used to move people, must be serviced at least six monthly to ensure people's safety. The lifting equipment at the home had not been inspected for over 12 months. We told the registered manager to take immediate action to address this serious shortfall and significant risk of harm to people.

On the second day of inspection the deputy manager had arranged for the lifting equipment to be serviced by an external organisation who were competent to complete these LOLER safety checks. Following the LOLER inspection the bath hoist was assessed as unsafe for use. Fixings had become loosened which placed people at risk of serious harm. A hoist sling was also condemned as it was unsafe. The registered provider had not taken appropriate action to ensure the equipment was safe before we had identified the issues.

Environmental risks to people were not adequately managed. People were not fully protected from the risks associated with fire safety. The fire service visited the home on 21 November 2017 and recommended that the risk assessment be completed by a 'competent' person' which they indicated would be a qualified 'fire risk assessor.' We discussed the fire risk assessment with the registered manager as records showed that they had completed this and reviewed it on 19 June 2018. We asked the registered manager to demonstrate how they were a suitably 'competent person' to safely complete this risk assessment. They were not able to show us that they were suitably skilled to fulfil this risk assessment for people. The previous fire service inspection also recommended that the fire alarm system be replaced and updated to a new model as the existing systems was '15-20 years old.' We addressed this with the registered manager. They told us that they were not aware of this recommendation within the report from the fire service. Risks were therefore not adequately managed.

People were placed at risk from unsafe water quality monitoring and inappropriate shower head hygiene practice. Water quality had not been monitored for the presence of Legionella. There was no policy for water quality. The registered manager also confirmed that shower heads had not been descaled regularly or disinfected to further reduce risks of legionella bacteria being present. The Control of Substances Hazardous to Health (COSHH) 2002 states that these checks must be completed by a competent person. This placed people at risk of exposure to Legionnaires Disease. By the second day of inspection the deputy manager had

put measures in place which meant that these checks would be completed in future.

Medicines were not always managed safely for people. At the time of this inspection, nursing staff who gave medicines to people had not completed medicines management training and had not had their competencies assessed to demonstrate that they were safe to give medicines to people. We saw that nurses had been disciplined for medicines errors, but no further training or competency assessments had been completed following these errors. No changes were made to the monitoring of medicines following errors which meant that practice which had contributed towards medicines errors could be repeated. This placed people at risk of not receiving their medicines safely and indicated that lessons weren't learned when things went wrong. The Nursing and Midwifery Council (NMC), who regulate the practice of nurses, recommend in their 'standards for medicines management' publication that, "A policy must be in place and adhered to in assessing the competence of an individual to support a patient in taking medication. A record of the individual's training and assessment should be kept, and all refresher or continuing education and training should also be routinely kept." This guidance had not been adhered to at the time of this inspection and no records could be found of nurse competencies to give medicines to people. This meant the provider could not be assured that the nurses were competent.

We saw in a medicines audit completed by a nurse for June 2018, that another nurse had 'borrowed' medicines from one person to give to another person. We spoke to the nurse who had completed the audit who confirmed that no management action had been taken at that time to address this risk of unsafe practice which may place service users at risk of significant harm. Medicines should only be given to people that have been prescribed for them and should never be shared with other people. The National Institute for Clinical Excellence (NICE) states in the 'managing medicines in care homes' publication, that, "Medicines belong to individual people living in care homes and must not be shared between residents, even if 2 of them are taking the same medicines."

Systems for monitoring the safe use of medicines were not robust. We saw a medicines audit report completed by an external pharmacy on 29 June 2018. The audit report noted that, "there were inconsistencies on how the team understand the administration process" and that there were "unsigned gaps on the MARs" (medication administration records). We were told by a nurse that there were no "formal omission checks or process" in place.

The providers policy for giving people their medicines by covert means was not clearly understood by nurses. For one person, the GP had agreed medicines could be given covertly. We saw that the covert medication care plan for the person had not been completed or reviewed regularly or robustly as to how often the medication is given covertly (no record of when and how). This placed the person at risk of not receiving their prescribed medication when they needed it.

Homely remedies and creams that were prescribed for people were not always used safely. Homely remedies are medicines that are non-prescribed medicines which are available 'over the counter' in community pharmacies and used in a care home for the short- term management of minor conditions, such as a headache and minor pain. We found that not all homely remedies had been correctly used. For example, we saw 'paracetamol suspension' and 'calamine lotion' which did not have a date that they were opened. Calamine lotion should not be kept for multiple usage but for single usage for an identified individual and disposed of after use and replaced with new bottle. We could not see evidence that this had happened. This meant that people may have used lotions that were 'out of date' and also may have exposed people to risks of infection with multiple use of calamine lotion. We found that creams held in people's bedrooms had not been regularly checked to see when they required replacement after they had been opened for an extended period of time. The deputy manager had implemented new systems during the

inspection which would more effectively monitor this and therefore mitigate future risk.

The registered manager had failed to put measures in place which ensured that people received their medicines safely and in line with best practice and legal requirements.

These are breaches of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Systems used to assess staffing levels were not always effective to identify if there were always enough staff to meet people's needs fully. A nurse told us, "Staffing is not too bad." The registered manager told us that, "I think the mistake we've made is that it was steady for a long period of time and now we've taken on higher level needs" and "I think we need a cut-off point and not be full." We were told that there were five care staff on duty each morning and one nurse as well as the registered manager and/or the deputy manager. At night there was one nurse and two care staff. During the inspection we saw that there were sufficient staff to respond to people's needs in communal areas. However, we reviewed the dependency tool that the registered manager had used to assess the levels of need and the levels of staff required to meet the identified needs. We found that at the end of June 2018, 21 people's needs were assessed as a 'medium' level of need, with only one person assessed as 'low' needs and one person assessed as 'high' level needs. We asked the registered manager what level of support a person with 'high' level needs would require above those with a 'medium' level of assessed need. They were not able to provide a clear response to this question. A GP told us, "The home are trying to care for a large number of people with very complex needs which is challenging for them." We saw that a number of people were cared for in bed, some who were living with dementia who required 'full care.' This meant that the dependency assessment tool did not sufficiently assessed the levels of staff required to meet people's needs fully.

People were protected by recruitment practices. Staff files showed that appropriate recruitment checks had been completed. This included Disclosure and Barring Service (DBS) checks and employment references from previous employment. This meant that staff were of good character to work with vulnerable people.

Infection control measures were in place. There was a dedicated team of housekeeping staff and the home was clean and free of unpleasant odours during the inspection. There was an infection control 'lead' member of staff and monthly audits were completed to monitor the cleanliness of the premises. We saw that staff used personal protective equipment (PPE) correctly.

People were safeguarded from abuse. Staff received training to understand safeguarding processes. When we spoke to a member of staff about safeguarding and asked what it meant, they said, "to make sure they [people] are safeguarded against" [abuse]. When asked as to the process to raise concerns, they said, "I would contact all of the medical professionals involved and the GP." We also spoke to a relative of a person who told us that they were happy with the person living at the home and felt that they were "safer" than when they were living at home. A person told us they were happy at the service. Another person said, "oh yeah" when we asked if they felt safe at the home. A GP told us, "My overall feeling is there is no neglect" and "I haven't had major concerns."

Requires Improvement

Is the service effective?

Our findings

At the last inspection this key question was rated as 'Requires improvement' and we recommended that the registered person reviewed and implemented support systems to ensure all staff received regular, formal supervision and appraisal. This inspection found that this had not been addressed and staff did not receive regular supervision or appraisals.

The deputy manager told us they had not received a supervision for 18 months since they started in their role at the home. Staff who had been disciplined for medicines errors did not receive additional training or support to improve in their roles. A nurse who was not clear what supervision was as they had not received this at the home. They did say that the nurses met with the registered manager to discuss concerns with other nurses approximately twice a month but they were not provided with individual supervision. The nurse had also been disciplined for errors in their role. Whilst there were group supervisions staff were not provided with opportunities to review their individual learning needs with the manager.

Staff did not always have the right skills, knowledge, training or management support to provide effective care and support to people. Care staff, the cook and the registered manager had not received training to support their understanding of diabetes. Other nursing staff had completed diabetes training although the care staff and the cook were the main staff who actively supported people with meal time and care needs. Some people who lived with diabetes at the home were not able to express their wishes and needs verbally due to living with dementia. This meant that people's needs were not always met in line with their 'protected characteristics.' The Equality Act 2010 covers groups of people that are protected in law to ensure that they are treated fairly and have equal access to appropriate support as other people who do not live with protected characteristics. 'Protected characteristics' include, but are not limited to, age and disability. Dementia and diabetes are protected characteristics. The cook told us that they gave a person living with diabetes a "smaller portion" of foods. We observed the person's lunch time meal which had not been adjusted to a smaller portion. There was a lack of understanding about providing effective diabetes care.

Some staff had 'lead' roles within the home. The registered manager was not clearly able to tell us what this meant for different staff who held these roles. Trained nurses did not receive an induction specific to the service when they started as new staff there. Nurses did not receive observed practice or clinical supervision to assess their competence. The Royal College of Nursing and Nursing and Midwifery Council (NMC) state that employers have a responsibility to ensure that, 'new employees receive a thorough induction into their area of work', 'training and supervision', 'ongoing access to professional development' and 'clinical supervision.' Induction and training was therefore not in line with best practice guidance which had resulted in medicines errors.

The deputy manager told us that they were a 'train the trainer' for eight areas of training that were considered as mandatory training by the provider. These included, but were not limited to, Safeguarding, moving and handling and medicines management. There was a lack the of training for nursing staff in medicines management. The training provision at the home was not always effective and did not ensure

that staff always had suitable expertise in their roles.

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

People's needs and choices were not always assessed to achieve the most positive outcomes for them. Records held for people did not always accurately reflect their current or personalised needs or choices and we could not see how people had been involved in their care plan assessments. Staff confirmed that records were out of date for people that were held in their bedrooms. For one person their care plan indicated that they were able to walk with staff support but we observed that the person was cared for in bed and was not able to move without the use of lifting equipment. For another person, records that described the equipment needed was unclear with a lack of clarity regarding if a 'hoist' or 'stand aid' was required. For a further person their 'diabetic care plan' was not detailed and said, "ensure diabetic diet offered" without any supporting information to indicate what this may include. We found that people's care records contained limited information regarding mental capacity assessments which should be decision specific. There was a lack of clarity about the actual decision being made for people who are not able to consent to their care or treatment in an informed way.

Consent to care and treatment was not always sought in line with legislation. Namely the Mental Capacity Act 2005 (MCA). The registered manager, nurses and care staff did not fully understand the principles of the MCA. The mandatory training for the home did not include MCA training for staff. The 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. We spoke to the registered manager and nurses and asked about their understanding of the MCA in practice at the home. One nurse said, "it's about the resident coming first" and "understanding their values and beliefs" and that they were "awaiting the six steps training around this." The 'six steps' training refers to an end of life care training and not MCA or Deprivation of Liberty Safeguards (DoLS). 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. An advocate who worked with people who had DoLS authorisations in place told us that they work with the home to make sure that DoLS "conditions are always met." The registered manager was unable to clearly describe the principles of the MCA to us. A nurse did not understand 'covert' methods for providing care and treatment for one person who had a covert medication care plan. Care staff were not able to describe MCA principles in practice, but we did observe care staff asking people for their consent before they provided them with meal time support.

The registered provider and registered manager had failed to ensure that appropriate training was provided to staff regarding MCA and DoLS. People were supported who lived with dementia and were not able to always give informed consent about day to day decisions. Staff did not understand the legal aspects of this.

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

People were supported to eat and drink, although there were limited individual or personalised choices of foods available. The cook told us, "We don't have choice" (of meals for people). People should be provided

with choices of foods and be involved in decision about the meals provided to them. The cook told us that they design the menu's based on what they know people "don't like", but not focused on people's preferences. The cook also said, "if someone doesn't like something we don't give it to them" and "when a new resident comes in we find out what they don't like." We received mixed views from people about the food they received. We asked one person who was able to express their views if they were asked about their food choices. They said, "no they (staff) don't ask you" and "they give it to you whether you like it or not." They also said, "but I would tell them if I didn't like it." We also asked if they were able to ask for what they would like to eat each day. They said, "not really." Another person said, "food is very good."

People's 'dislikes' regarding foods were known, as well as those who may have dietary needs such as, diabetes and certain food allergies. However, the foods that people liked were not recorded which indicated a lack of person-centred choice or preferences being adhered to for meal times. The cook told us that one person had a particular food allergy and said that they would "give them a different sandwich filling" to address this. We spoke to a community dietician who had worked with the service before this inspection. They told us that "the home did not have a chef in the evening and as a result tinned food-stuff or sandwiches are the only available supper options." The cook confirmed that this was the case and said that, "(people) have sandwiches every day at tea time or soup" and "they have cake and cheese and crackers." This provided a limited choice for people who may prefer a cooked or other meal choice in the evenings.

The home had been identified by local community dieticians as a service that supported a high number of people who were at risk of malnutrition. The home took part in a nutrition 'pilot' study in November 2017 which aimed to support providers to improve the nutrition of people living at services. The pilot was called 'nutrition resources in care homes' (NRICH). A community dietician told us that the home had improved their management of malnutrition with the additional support and resources that were provided to them. Some areas for improvement were identified in November 2017 as part of NRICH. One area for improvement was to, "Ensure carers are encouraging and prompting regularly and consider availability of alternative options if resident eats little/nothing." The cook told us that "snacks were available throughout the day" which mostly consisted of "biscuits" and "cakes" being offered throughout the day with hot drinks. This did not promote a healthy lifestyle for people who lived with diabetes.

The registered provider had failed to provide people with choices regarding their preferences of meal options.

We recommend that the registered provider ensures people have choice of foods to meet their nutritional needs and personal preferences.

The cook also told us that some people who were at risk of malnutrition would be offered "snack boxes" to promote weight gain. We observed that staff supported people sensitively and in a person-centred way during their meal time. Staff wore appropriate protective equipment and one person was supported to enjoy their meal in the garden as they had chosen.

People had access to healthcare. We spoke with the GP who supported the home who told us that, "I and the specialist nurse and community matron have been involved with and supporting the home to meet the complex needs" (for people). Records for people showed that healthcare professionals had been contacted when people required this. During the inspection a person was unwell. The person had a history of 'sepsis.' Sepsis is a life-threatening condition that requires urgent treatment. The nurse was observed to call the doctor surgery to discuss the persons known history of developing sepsis. They then proceeded to make the decision to call an ambulance for the person to ensure their wellbeing. The person was seen and treated by paramedics. The nurse acted in accordance with best practice guidance such as the 'Sepsis: recognition,

diagnosis and early management' guidelines published by the national institute for clinical excellence (NICE). We also spoke with a community admission avoidance nurse who regularly visited the home to work with the staff.

The premises were adapted to support people. People were able to choose their personal items to have in their bedrooms and there was signage on bathroom and toilet doors so that people were able to orientate themselves around the home when they were physically able to do so.

Other care records for people were completed positively. These included a 'transfer letter' which was completed for when people moved between services which included hospital admissions. The document included basic information about the person, their baseline observations, any allergies, next of kin and what was being sent with the person. This included, 'dentures' and 'DNACPR'. This is a useful tool which may support people to move between services more positively, with staff in those locations understanding the person's needs when they may be living with dementia and unable to express their preferences or needs.

Requires Improvement

Is the service caring?

Our findings

At the last inspection this key question was rated as 'Requires improvement' and we found that there were mixed views from people about how they felt about the care they received. Some staff did not always use language that respected people as adults or individuals. For example, they were heard referring to people who required assistance to eat in their rooms as "The feeds." At this inspection we found that for some staff this was still the case. We spoke to a nurse who told us that, "Feeds start at 11:50 and the other meals start about 12:15." This was not valuing of people and their individual needs.

People's dignity, including personal expressions of their identity were not always maintained. For example, we saw for one person who was living with dementia, that within their 'hygiene' care plan it was noted that their "hair will be brushed in a style of their choosing." However, the 'communication' care plan for this person indicated that they were "unable to voice her needs verbally." Agency staff were used from external organisations. Without up to date information about people's personal preferences, agency staff would not know the personalised needs and choices of people well enough to provide support appropriately for them.

People were not always treated with kindness and compassion. We observed a person at the end of their lives being supported to eat their lunch time meal by an agency member of staff. The agency staff interaction was not compassionate or sensitive to the person and empathy was not demonstrated. This person was being cared for in bed and the agency staff positioned themselves to the side of the person and did not communicate with them throughout the meal experience. The person was not able to see where or who their food was coming from as this was put into their mouth by the staff member. The experience was rushed. We reported these concerns to the management team immediately. We were told that the agency staff would not be returning to the service.

Confidentiality for people was not always maintained. Records containing personal and confidential information about people were held in accessible cupboards. Throughout the inspection the cupboards which held records for people were not locked and at times these were left unsupervised by staff. New legislation became effective from the 25 May 2018, namely the General Data Protection Regulations 2018 (GDPR). The GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. We reviewed the Data Protection policy which had not been updated to reflect this important change in legislation.

This is a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we observed that permanent care staff interacted sensitively and showed kindness towards people throughout the inspection process. We saw that permanent staff knew people well and were seen to engage respectfully with people. For one person we observed very positive interaction with a member of staff. The care staff explained what was being offered and time was taken to assist and help the person at their pace. The staff member sat facing the person directly so that eye contact was maintained. The person did not communicate but was spoken to throughout the observation. This was a very personalised

observation that placed the person at the centre of the meal time support they received. A person told us that, "they're very nice people (staff)."

People were supported to express their views regarding decisions about their care and the deputy manager worked to support people to maintain their independence. The deputy manager had supported people to receive support from advocacy services at the home. Advocates provide independent support and advice to people. We spoke with the advocate who told us about the people who they supported at the home. They said that the deputy manager was, "thinking all the time about what she can do to make things better" (for people) and that the deputy manager takes a person to art class each week that they had sourced for them. They also said that the person is made to "feel very important" when they go to the art club and that they "look forward to it all week." We spoke with the person and they told us how important it was for them to be able to access the local community and how they had been able to do this independently until more recently in their lives.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection this key question was rated as 'Requires improvement' and we found that the contents of people's assessments and care plans varied in accuracy and detail. We also found that the Accessible Information Standard (AIS) had not been imbedded in documentation for people. At this inspection we found that this was still the case.

People's needs were not always reviewed when things had changed regarding their care needs and their care plan records did not always reflect their current needs. Care plans did not always show how people should be supported when they lived with a disability such a dementia or diabetes which meant that their 'protected characteristics' were not always reflected. Records did not clearly show how people and/or their representatives had been involved with the decisions about care received at the home. Records did not always show if appropriate actions had been taken following treatment or intervention for people. For example, for one person, a blood test had been taken but documentation was incomplete and did not indicate the results of the test or if any follow up action may be required. This meant that we could not be assured that the person had received treatment needed, if any, in response to the test completed.

Systems were not always robust to enable people or their representatives to raise complaints about the service if they wished to do so. People were not always able to personally raise complaints about the care they received because they were living with dementia and relied upon others to do this in their best interests. There were no accessible formats for people to use to enable them to raise a complaint in a format that was understood by them. Relatives meetings had not happened in the last 12 months. We could not see the involvement of people's representatives at care plan reviews or other opportunities provided to them where they may be enabled to voice any concerns they had. However, the registered manager showed us an example of a complaint that had been handled appropriately which indicated that for some people, access to the complaints process was appropriate. This is an area that requires improvement.

People received end of life care at the home. We spoke with a community paramedic practitioner who told us that they provided some support to the home regarding end of life care planning for people. The GP told us about one person who lived in the home who had "end of life medicines" in place with "pain relief for their symptoms." This demonstrated that the home worked with the local community health professionals regarding people's end of life care needs.

The registered manager spoke passionately about providing people with the "right" care and treatment at the end of their lives and said that they had completed the accredited end of life "six steps" training with the local hospice. Some people's records contained a 'DNACPR' form. The registered manager and staff understood what this form was used for. These forms are completed by a medical professional, either with the person or in the person's best interests if they are not able to give their views of their care at the end of life. When this is in place a person would not be resuscitated. This enabled people to die with dignity when it had been professionally agreed that resuscitation was not appropriate for them.

The registered manager also told us that the hospice had recommended that the staff placed a 'heart' sticker on people's bedroom door if a DNACPR was in place and a 'butterfly' sticker for those people who were at the end of their lives. The registered manager couldn't tell us if people or their representatives had been asked if they were happy with this identification on their bedroom doors, when visitors and others in the home were also able to see these. We also noted that if a person passed away or moved rooms that there needed to be a process that ensured that the sticker on the door was removed. This is an area that requires improvement to ensure people receive appropriate end of life care.

Technology, such as 'falls' sensor mats were used to alert staff when people may have fallen in their rooms. Falls were also monitored and recorded on the registered managers 'monthly audit' and actions noted if referrals were required to falls prevention services outside of the home. This ensured that people's needs were responded to appropriately when they were at risk of falling.

People were supported to go into the community and to take part in activities that were meaningful to them. We were told by the deputy manager of some positive examples of a person being supported to access community based art classes that they had sourced for them. The person lived with a disability and we were told by an independent advocate how they had done "a lot of work with the deputy manager regarding community access for one of our clients" and how much the person "thoroughly enjoyed art classes." Another person who lived with dementia had been supported by the deputy manager to create a 'sensory box.' The advocate told us how the sensory box had helped the person to "feel it's (Burlington Nursing Home) her real home and that that she sometimes also has a doll. They also said that "They've (staff) spent a lot of time with her to see what she responds to" and that "some days she really enjoys looking after her doll." We observed that the person used a doll during our inspection. The registered manager told us how the doll can also be positively used as a distraction aide which enabled staff to provide personal care for the person when they needed this. The advocate also said, they've (staff) done a lot to make her feel that it's (person's room) their space when their husband visits" and that "they've (staff) created a proper safe happy little place for her and her husband." This demonstrated that staff knew these people's needs well and were able to respond to their individual circumstances positively.

Inadequate

Is the service well-led?

Our findings

At our last inspection a breach of regulation was identified and a requirement action made in relation to good governance. The registered manager sent us an action plan that detailed steps that would be taken to achieve compliance. At this inspection we found that insufficient action had been taken and that there was a repeated breach of this Regulation and further breaches of other Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There has been an ongoing historical failure to maintain the service to a 'Good' standard. At the previous inspection on the 29 June and 3 July 2017, the service was rated as 'Requires improvement' in all five key question areas. The service was inspected on 4 and 5 October 2016 and was rated as 'Requires improvement' overall, with the 'Safe' key question rated as 'Inadequate.' There were also six breaches of Regulation. While there had been some improvements in 2017 we found that these had not been sustained at this inspection.

At the 2016 inspection risks to people were not adequately managed. At this inspection, we found that risks to people's wellbeing continued not to be managed safely or effectively and measures to mitigate risks were not adequate to keep people safe from harm.

Quality systems and processes were inadequate and records did not provide up to date or consistent information about people living at the service. For example, daily care notes that were kept in people's rooms were completed by carers. The registered manager told us that there was a 'handover' folder for carers with a report sheet for carers to use to 'flag' any concerns they may have about people to the nurses. We did not see that this was being used effectively. The handover forms had not been signed off or any action noted by nurses. We also saw records for one person completed by a nurse who worked at night, which indicated that the person's oxygen levels were dangerously low with no action taken and no feedback to day nurses in the handover process. We spoke to another nurse and asked them to address this. The nurse told us that this was a "mistake" but agreed to immediately check the welfare of the person concerned. The person concerned did not come to harm as a result of this, but this highlighted a lack of appropriate response to concerns raised by nursing staff in a person's daily notes. This ineffective system placed people at risk of not receiving the right access to healthcare when they needed it. Service monitoring had not identified that equipment used to move people, when they were unable to do this for themselves without support, had not been maintained and were not fit or safe for use.

Systems were not in place to monitor the water quality or implement appropriate cleaning schedules to keep people safe from the risks of Legionella bacteria being present. There was no policy for how water quality would be safely maintained at the service and no action had been taken to meet the actions required in law to keep people safe from Legionella bacteria in care home premises. We addressed this with the registered manager and asked them to take immediate action to keep people safe.

Systems did not always adequately protect people from the risks associated with poor management of fire safety arrangements in the home. The fire risk assessment for the premises was not completed by a

'competent person' as required by the fire service.

Medicines were not always managed safely for people and staff were not always competent to safely give medicines to people. The registered manager had not ensured suitable training or competency assessments were in place to demonstrate staff were competent to give medicines to people safely. A medicines audit was completed by an external pharmacy on the 29 June 2018. The audit highlighted 'unsigned gaps on MAR's' (medication administration records). At the time of our inspection on the 11 July 2018, no corrective action had been taken to fully investigate or address these gaps. This indicated that the management did not learn from highlighted areas of risk or placed other corrective measures in place to avoid reoccurrences in practice.

Systems and process were not being used effectively to identify or manage shortfalls in the service adequately. The registered manager told us in their previous inspection action plan that, "I will audit care notes monthly, we have split them into groups for nurses to review and update spread over the month so that there is more time to audit more fully and follow up, each nurse is responsible for specific notes so it will be easier to direct action needed to the person responsible for the omission or correction needed." Despite this, records in people's care plans in their rooms were out of date and did not accurately reflect people's needs. For one person being nursed in bed, their care plan indicated that they were mobile. Agency staff from an external organisation were used at the home who may not know people's complex needs as well as regular staff in the home. Out of date records may have placed people at risk of harm with unclear instruction or guidance of required actions to meet people's individual needs and manage any risks safely. The registered manager had not implemented the additional measures they had agreed following the previous inspection. This was a repeated breach of Regulation.

People's views had not been sought of the service they received since 2016. Therefore, people's experiences of the service they received were not listened to in a structured way.

The registered manager and registered provider had failed to ensure that adequate systems, processes or measures were implemented to keep people safe from risks of harm occurring.

This was the third consecutive breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not maintained their knowledge and understanding in their role and did not ensure that we were notified of incidents that they are required to tell us in law. We found that five people had received Deprivation of Liberty Safeguards (DoLS) authorised applications. We require that registered managers tell us when this happens so that we can safely monitor that correct systems are being followed for people. We were not notified of these notifiable incidents. However, the registered manager told us at the inspection that they "didn't know" they had to notify us of DoLS authorisations. At our previous inspection in 2016, it was noted that "authorisations of DoLS had not been shared with us." Following this inspection, we received the five DoLS notifications from the provider.

This is a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (registration) Regulations 2009.

The registered manager and provider did not demonstrate that they had continually learned following from our previous inspection ratings and the registered manager did not understand the principles of good quality assurance. We received mixed reviews about the service from external health and social care professionals.

There was little evidence of a culture that promoted a reflective practice model of learning and as a result we saw that staff had been disciplined repeatedly, primarily as a result of medicines errors but had not received ongoing support or training from the registered manager to enable them to practice safely in their roles. The registered manager had failed to positively engage with these staff or listen to their feedback for improvement. We did not find that the nurses had received robust training, competency assessments of their practice or regular supervision or appraisals to support them in their roles.

Due to the ongoing concerns that were identified at this inspection, the registered provider told us that they would source a professional external consultant to support the service to identify all areas of concern and to seek to improve practices. Following this inspection, we received an action plan from the registered manager. This demonstrated that they had begun to address the shortfalls identified at the service. We will review this at the next inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications had not always been sent to the CQC as and when required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect by agency staff used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not always understand the principles of the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always suitably trained or skilled and had not received regular supervision in their roles.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from the risks of significant harm or injury occurring.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance the registered provider failed to implement systems and process to effectively monitor the quality and safety of the service.

The enforcement action we took:

Warning notice