General Medicare Ltd

Burnham Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook this inspection of Burnham Lodge Nursing Home on 17 and 21 August 2017. The first day of the inspection was unannounced. We arranged to visit on the second day of the inspection with the registered manager.

Burnham Lodge Nursing Home provides residential and nursing care for up to a maximum 23 people. At the time of our inspection, 18 people were living at the service. The service specialises in caring for older people including those with physical disabilities, people living with dementia or those who require end of life care.

There was a registered manager in post. 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.

People did not consistently receive safe care. Where risks had been identified to people's safety, we found suitable measures were not always put in place to reduce the identified risks. Staff were not always recording incidents when they occurred. Staff were not receiving effective clinical supervision.

Medicines were not always stored securely and there were no clear protocols in place giving staff instruction on when and how 'when required' medicines should be given. People were happy with the way staff supported them with their medicines and we observed medicines were administered safely.

The home was not consistently clean and there were areas of the home that needed improving. Risks to legionella bacteria in the water systems and water temperatures were not being managed consistently. The provider had a refurbishment plan in place for the home identifying areas for improvement.

There were not always enough staff or activities available to meet people's social, emotional and wellbeing needs. Staff did not always follow health professional advice or guidance.

People's rights were not fully protected because the home had not consistently acted in accordance with the Mental Capacity Act 2005 (MCA).

People's mealtime experience was mixed. People commented positively about the food, and food was prepared to meet their individual needs.

People's care needs were not always fully assessed and planned for. Some of the care plans we reviewed included contradictory information.

Quality assurance systems were not always fully effective at identifying and addressing shortfalls in the service provided.

People told us they felt safe at Burnham Lodge. Staff knew how to recognise and report abuse and recruitment was managed safely. People's healthcare needs were met.

Staff received appropriate training to understand their role. New members of staff received an induction which included shadowing experienced staff before working independently.

People and their relatives told us the staff at Burnham Lodge were kind and caring. People were treated with dignity and respect. People or their representatives were fully involved in decisions about their care and treatment, including the care they would like to receive at the end of their lives.

People and their relatives knew how to complaint and felt confident any concerns would be responded to.

People were supported by a staff team who felt supported by their manager and were positive about working in the home. Staff felt able to approach their managers and raise any concerns.

There were systems in place for people, their relatives and staff to give their feedback on the service.

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.

Risks to people were not always identified, mitigated or managed.

There were some shortfalls in the management of people's medicines.

People thought there were enough staff available to meet their needs.

People were supported by staff who knew how to recognise and report abuse.

People were supported by staff who were recruited safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People's rights were not fully protected because the principles of the Mental Capacity Act 2005 were not always being followed.

People were supported to have enough food and fluids.

People were supported by staff who felt supported in their role.

People were supported by staff who received training to carry out their role.

People's healthcare needs were supported and met.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People were supported in line with their preferences.

People's end of life care was assessed and planned for.

Staff demonstrated a caring approach when supporting people.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's needs were not fully assessed and planned for.

People's need for occupation, stimulation and activities was not fully assessed and planned for.

People and their relatives knew how to complain and there were systems in place to receive their feedback.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The quality assurance systems in place were not fully effective in monitoring and reducing risks to the health and welfare of people.

People were supported by staff who felt able to approach their managers.

The provider had notified us of significant events in line with their legal responsibility.

Burnham Lodge Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 21 August 2017 and was initially unannounced.

The inspection was completed by two adult social care inspectors and a specialist advisor who was a registered nurse.

Before the inspection we reviewed information we had received about the home, including notifications. Notifications are information about specific important events the service is legally required to send to us. We looked at the Provider Information Return (PIR) prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they planned to make.

During the inspection we spoke with eight people and three relatives about their views on the quality of the care and support being provided. We spoke with the registered manager and 10 members of staff including the cook and the cleaner. We also spoke with two visiting health professionals.

We looked at care documentation relating to 14 people, 18 people's medicines administration records, four staff personnel files and records relating to the management of the service, including quality audits.

Inadequate

Is the service safe?

Our findings

People did not consistently receive safe care. Where risks had been identified to people's safety, we found suitable control measures were not always in place to reduce the identified risks. We found some of the care plans we reviewed included conflicting information for staff to follow and staff were not always recording when people had been involved in incidents, which put the safety of people at risk.

For example, one person had a risk assessment in place for the use of bedrails to prevent them from falling out of bed. Where people have bed rails in place, a thorough risk assessment should be carried out relating to their use and the risk of the person becoming trapped in the bed rails. The person's risk assessment stated bed rails were not to be used because the person may try to climb over them, and it also stated if it was felt necessary by staff the rails could be used. However, the person's care plan also stated the bed rails should not be used because of the identified risks involved.

We looked at the person's daily records and noted an incident where they had been observed by staff to have put their legs through the bedrails and had bruising on their knees as a result. We discussed this with the registered manager who was unaware of this incident. There had been no incident form or record of the bruising completed by staff. By staff not recording and highlighting this incident meant that no further measures were put in place to reduce the risk of the person becoming trapped in the bed rails or injuring themselves if they tried to climb over them.

The person's daily records stated that bed rails had been used on four further occasions following the incident. We spoke with staff about the use of the bedrails and they gave us conflicting information about whether they were being used or not. This meant the person was placed at further risk of climbing over the bed rails or putting their legs through them. We discussed this with the registered manager who immediately communicated to all staff that the bed rails should not be used. They also confirmed the care plan and risk assessment would be updated to reflect this. Following the inspection, the registered manager confirmed they had audited all of the bedrails being used by people in the home to confirm these were being safely used. They told us some of the beds required new bed rail covers and these were being ordered.

We found some incidents had not been identified or managed appropriately to keep people safe. For example, one person's daily records stated they had bruising on their arm. There was no incident form or body map of the bruising completed by staff. Body maps are ways providers can record on paper, any marks and wounds found on a person's body to enable them to monitor these. We discussed this with a nurse who told us the person scratched themselves and held onto their own arm tightly which caused them to bruise; however there was no clear evidence of this information being recorded in the person's care plan. This meant the person was at risk because incidents of unexplained bruising were not being recorded and reported. We discussed this with the registered manager who told us they would ensure all staff would record any bruising so this could be investigated. Following the inspection the registered manager confirmed the person's records were updated to include the information about them holding their own arm. They described measures they had put in place to support the person to occupy their hands to help prevent

them from further doing this and causing further injury.

During the inspection, we observed one person had a wound on their leg and their leg was noticeably inflamed. The person was visibly distressed by the wound and was attempting to scratch it whilst we were observing them. We discussed this with the registered manager who told us they would dress the wound, complete a risk assessment and wound care plan and contact the person's GP. On the second day of the inspection, we saw the wound was dressed and a care plan had been put in place to guide staff on the action they needed to take and address any potential risks.

People had individual guidelines in place that were written by health professionals where they were at risk of choking or aspirating whilst having food and drink. The guidelines included clear guidance on the required texture of the food and drink, the correct positioning of the person whilst they were eating and drinking and the staff observation required during the meal to ensure people remained safe.

On the first day of the inspection, we observed two occasions involving two different people where these guidelines were not being followed, placing the people at risk of choking or aspiration. One person was observed to be eating whilst laid horizontally on their back in their bed, their guidelines stated they should be 'sitting upright and alert'. The person's guidelines also stated staff should 'supervise vigilantly from a distance'. Staff were not observing this person whilst they were eating, and when we discussed this with three staff members they all told us the person did not require direct observation. This meant the person was placed at risk because staff were not aware of and following these prescribed guidelines issued by a health professional.

Another person was observed by our inspection team sat in the lounge with their meal and they were in a slouched seating position, we observed the person coughed twice whilst eating their meal and they were left for periods of time without any staff support. Staff told us this person had choked in the past and the guidelines had been put in place in response to this. We discussed this with the registered manager who reassured us they would ensure all staff were aware of the guidelines and following them. This meant the person was also placed at risk because staff were not aware of and following these prescribed guidelines issued by a health professional.

On the second day of the inspection, we observed the person who we had previously observed sat in a slouched seating position had been supported to sit in a different chair which supported them to have a better seating posture whilst eating. However, in the afternoon we observed they had again been left alone with their meal without staff supervision. This meant staff were still failing to follow the person's guidelines and the person was placed at risk of choking or aspirating on their food. This was despite this risk being previously identified to the registered manager by the inspection team on the first day of our inspection. We again brought this to the attention of the registered manager who responded by implementing an allocation chart for the two people we identified at risk to ensure an allocated member of staff would be identified on each shift to support them with their meals. We raised a safeguarding alert with the local authority in relation to our observations and subsequent concerns.

Following our inspection the registered manager confirmed they had arranged for an allocated staff member on each shift to support both people with their meals, they also said they were ensuring staff were recording the support given and all staff were in the process of reading and signing the guidelines to acknowledge and agree to follow them. The registered manager told us they were arranging for reassessments of both of these people in relation to their eating and drinking requirements to ensure the guidance remained up to date and accurate.

Where people received support in their beds and had pressure relieving mattresses in place, not all of the mattresses were set at the correct pressure for the person's weight. Pressure mattresses reduce the risk of people developing pressure ulcers. We looked at the mattress settings for seven mattresses and noted four were not set at the correct pressure. Nobody living in the home had pressure ulcers and the nurse told us they would rectify the under inflated mattresses straight away. The registered manager told us they would ensure there was a system in place to regularly check the mattress settings to ensure they were accurate.

During our inspection, we looked at the systems in place for managing medicines, looked at people's Medicines Administration Records (MARs), and checked how medicines were administered to people. We spoke with staff involved in managing and administering medicines, and observed some medicines being given to people.

We found some aspects of medicines management needed to be improved. Some people were prescribed medicines to be taken 'when required', for example paracetamol. We found there were no clear protocols in place giving staff instruction on when and how the medicines should be given. For example, one person had been prescribed two separate medicines to be given if they became unwell. There were no guidelines in place detailing what signs to look out for to indicate the person was becoming unwell or at what point the medicines should be administered. There was also no guidance stating the two medicines should not be administered at the same time. This information is important because some medicines can contain ingredients which could interact with each other and have a negative impact. It is aso important to record the maximum dose of the medicines to be given in a 24 hour period to prevent an overdose. Whilst the nurse on duty had knowledge of how the medicines should be administered, this information was not available for unfamiliar staff. We discussed this with the nurse who stated they would ensure this guidance would be put in place.

Most of the medicines were stored safely and securely in the home, however we observed thickening agents for people's drinks were left out in people's bedrooms. NHS England issued a safety alert in 2015 and advised appropriate storage of thickening powder as a result of someone ingesting and choking on the powder. We discussed this with the registered manager who told us they would ensure these were stored securely. On the second day of our inspection, we did not observe any thickening agents left out in people's rooms or communal areas.

The home had an audit completed by the dispensing pharmacy that supplied the home's medicines in February 2017. The pharmacist had raised a concern relating to a medicine syringe not being dated when it was removed from the storage in the fridge. Dating the syringe is important because it informs staff when it will be out of date and unsafe to use. We looked at the current syringe in use and found this was not dated. This meant the advice the pharmacist had given during their audit was not being followed and it was not clear if the syringe was still in date and safe to use placing people at risk.

We checked 18 people's current MAR charts. Charts were completed when medicines were given to people. We found five people's MARs had a staff member's handwritten entry for some of their medicines. We found these records were not signed or countersigned by two staff. This is recognised good practice to ensure people received the correct medicines and reduced the risk of errors occurring. We discussed this with the registered manager who told us they would ensure staff entries on the MARs would be signed and counter signed by two staff.

Risks to legionella bacteria in the water systems were not being managed consistently. Legionella can cause serious lung infections. The Health and Safety Executive (HSE) stated, "Health and social care providers should carry out a full risk assessment of their hot and cold water systems and ensure adequate measures

are in place to control the risks". The primary method used to control the risk from Legionella is water temperature control. Water services should be operated at temperatures that prevent Legionella growth". Although we saw a test was carried out by an external water testing company in November 2016 and legionella was not detected, we found regular checks were not being carried out on the water system to prevent the risk of legionella developing.

The registered manager told us there were thermostatic mixer valves in place to regulate the temperature of the hot water and staff told us they tested the water temperature before people were supported to bathe or shower to prevent the risk of scalding. However, they were unable to locate the records of the water temperatures to demonstrate they remained within safe levels. This meant people were not being fully protected from the risk of being exposed to legionella or the risk of scalding. We discussed this with the registered manager who told us the maintenance person was responsible for completing the water checks. They told us the provider had recently cut the maintenance person's hours, which meant they did not have the time to complete these checks. They said they would discuss this with the provider. Following the inspection the registered manager sent us evidence showing all of the hot water temperatures had all been checked and they were in a safe range, they also reassured us the required water system checks would be carried out in line with their legionella policy.

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

During the first day of the inspection we observed areas of the home were dirty and looked worn. For example, we observed old food ingrained on the carpet and chairs in the lounge, the windowsill in the lounge was dirty, and we observed some equipment in people's bedrooms was dusty and rubbish bins were full.

The registered manager told us the cleaners were off during the week of the inspection due to sickness and annual leave which impacted on the cleanliness of the home. However, we noted the night staff were responsible for cleaning the lounge area and it was apparent this had not been recently completed. We looked at the cleaning records and noted there were cleaners available most days. We spoke to one of the cleaners and they told us about their cleaning schedule, they said they thought they had enough time and resources to carry out their role effectively. On the second day of the inspection we noted the home clean and our concerns around cleanliness had been addressed.

Some of the bedrooms and communal areas had stained carpets, and we noted some people's wooden beds and bedrail covers were worn and there were areas of people's bedroom walls where the paint was chipped and missing. The registered manager told us that work had started on refurbishing the home such as the kitchen being replaced and also some of the carpets. They also told us the provider had a refurbishment plan in place and they shared this with us.

We also found there was a lack of storage space for the equipment people used. For example, wheelchairs, walking frame and hoists. One person had a hoist stored in their bedroom and we saw another hoist stored in the dining area.

At the back of the home there was a concrete outside area leading to a grass lawn that was assessable to people from their bedrooms. We found this area was not safe for people with poor mobility because the concrete sloped into the grass and the grass was uneven. We discussed this with the registered manager who reassured us people would not access this area and they would raise this with the provider.

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

The nurses administered medicines to people; no one self-medicated. People told us they were happy with the way the staff administered their medicines and we observed medicines were administered safely. One person told us, "I get my medication on time, I set my watch by it and if I need anything in between they get it for me." Staff received medicines administration training and a competency assessment by a senior member of staff was completed before they were able to administer medicines to ensure their practice remained safe.

Medicines were monitored to check that they were stored at the correct temperatures so that they would be safe and effective. There were suitable arrangements for storing and recording medicines requiring extra security. There were suitable systems in place for the destruction and return of unwanted medicines. The medicines for the people that we checked were available on the day of our inspection. Suitable records were kept of medicines received, returned and destroyed to enable an audit trail to check medicines management in the home.

People told us they thought there were enough staff available to meet their needs. Comments included; "The staff come quickly, I am never left" and, "Yes I think there are enough staff." Relatives told us there were enough staff, however one commented at times when the staff were busy supporting people they could be difficult to find.

Staff told us they thought there were enough staff available to meet people's needs and keep them safe. Comments included; "I think there are enough staff, we always have four staff on plus the nurse" and, "Staffing is perfect, there are enough staff on."

Our observations during both days of the inspection was that there were enough staff available to meet people's physical needs and people's call bells were answered promptly. We discussed staffing levels with the registered manager who told us staffing levels were set based on the needs of the people living in the home. They told us they did not use any form of dependency tool based on people's needs to calculate staffing levels. They confirmed their current staffing levels with us and told us if someone required additional support due to a change in their need they would increase the staffing levels to meet this. We looked at the staffing rotas and noted shifts were consistently covered with number of staff identified by the registered manager. We also noted the registered manager was working regular shifts as a nurse to cover instances of sickness and annual leave.

People told us they felt safe at Burnham Lodge. Comments included, "Yes I feel safe" and, "Oh yes I feel safe, I trust the staff impeccably." Relative also told us they thought their family members were safe. One relative told us, "[Name] is settled and safe." Another commented, "Yes I am happy they are safe here."

Staff told us, and records confirmed that staff received training in how to recognise and report abuse. Staff spoken with had a good understanding of what may constitute abuse and how to report it. Staff were confident that any concerns would be investigated to ensure that people were protected. Staff were also aware they could report concerns to other agencies outside of the organisation such as the local authority and the Care Quality Commission (CQC). One staff member told us, "I would report anything straight to the manager, I am confident they would definitely respond and if not I know I can go to outside sources such as CQC."

The home had a policy which staff were aware of and there was information about safeguarding and

whistleblowing available for staff in the office. One staff member told us, "I am aware of the whistleblowing policy and I would use it if I needed to, although I have never seen anything like that here." Another commented, "I would go straight to [name of registered manager] and I know I can whistle blow to CQC, I would 100% do this if I had to." This meant people were supported by staff who knew how recognise and report suspected or actual abuse.

The provider followed recruitment procedures to ensure that staff working with people were suitable for their roles. Staff had to attend a face to face interview and provide documents to confirm their identity. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work; records of these checks were kept by the registered manager. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people. References were also provided and checked. We found one file had the previous employment references missing, the registered manager told us they would locate the references and confirm these were in place. Following our inspection the registered manager told us they were obtaining new references for this person as they were unable to locate the original ones.

There were assessments, checks and emergency plans in place relating to the home and environment. These included fire risk assessments, personal emergency evacuation plans, checks on the call bell system, electrical equipment and checks on the environment.

Requires Improvement

Is the service effective?

Our findings

People's rights were not fully protected because the correct procedures were not being followed where people lacked capacity to make decisions for themselves. The service was not supporting people in line with the Mental Capacity Act 2005 (MCA). 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Where people had capacity to make decisions we saw some examples which showed they had consented to their care planning. However, where people lacked the capacity to make specific decisions the principles of the MCA were not always being followed. For example, two people had movement sensor mats in their bedrooms to enable staff to detect their movement because the people were at risk of falls. Both of the people did not have the capacity to understand the use of the equipment. There was no capacity assessment or best interest decision documentation in place for the decisions to have this monitoring equipment in place. Another person wore specifically designed clothing which staff described was in place to keep the person safe. Staff told us they had discussed this with the person's family who had agreed with its use. However, there was no capacity assessment completed or best interest decision made to ensure this was the least restrictive option and in the person's best interest. People also had restrictive bed rails in place to prevent them falling from their bed, again where people lacked capacity to consent to their use there were no capacity assessments or best interest decisions made. This meant people's rights were not being fully protected and current legislation and guidance was not being adhered to.

We spoke with the registered manager who told us they would review their processes for assessing people's capacity in line with the MCA. During the inspection, one of the nurses demonstrated they had started this process. The registered manager told us they would look into sourcing some further training relating to the MCA for themselves and the staff team to increase their knowledge of the application of the Act.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us they had received one authorisation to restrict a person's liberty under DoLS. They told us the family member had the outcome of the authorisation. We requested the registered manager provided us with the DoLS authorisation, however they could not provide us with this information. The registered manager told us they had made a further two applications to the local authority and they were waiting for the outcome of these. During the inspection, we identified a person who had recently moved to the service who required a DoLS application to be completed. The registered manager confirmed they had completed this during the inspection following us identifying the need to them for the application to be made.

The provider had a policy in place that identified the support staff required to help them meet the requirements of their role and support their development. This involved staff attending supervision sessions (meetings with their line manager to discuss their work). Staff completed a supervision agreement with their supervisor which set out the arrangements for the frequency, recording and content of the meeting. We looked at staff supervision records and noted the recording of the meeting did not meet the requirements of the supervision agreements. For example, the supervision agreement stated the regular items of the supervision should be; review of work, review of workload, attendance, future work plans and training and development. The supervision notes we reviewed did not include any of these subjects and had very little information recorded.

Staff told us they had regular formal one to one and group supervisions (meetings with their line manager to discuss their work) and they found supervision supportive. One staff member told us, "We have regular supervision and can request one when we want, they are helpful." Another commented, "We have regular individual and group supervisions they are good."

Staff told us they thought they had enough training and support to carry out their role. Staff told us they received an induction when they started working in the home and they commented positively about it. Records confirmed staff received an induction. One staff member told us, "The induction was good - I did a lot of shadowing and training, it covered everything." Another commented, "I shadowed a senior carer for a few shifts and was shown how to use all of the equipment. They put me in the hoist and I tried thickened fluids which gave an insight into how the residents feel. The induction is good here." The induction was linked to the Care Certificate. The Care Certificate standards are recognised nationally to help ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff also had an annual appraisal meeting with the registered manager to discuss their performance and provide them with feedback about their performance.

Staff commented positively about the training they received, they felt they had enough training to keep people safe and meet their needs. We looked at the training records which evidenced all staff received basic training such as fire safety, safeguarding, equality and diversity, moving and handling, infection control and end of life care. One staff member told us, "I've done my NVQ level one and two, the training is really good, we receive regular training and workshops, you just put your name down for any courses that are coming up." Another staff member said, "The training here is brilliant - if you have any concerns you can speak to [name of registered manager] and they will arrange more training. The dementia training gives you a bigger insight into the resident's different needs."

People commented positively about the meals they received. Comments included; "The food is very good, if you don't like it you are fussy" and, "The food is very good and enough of it, I think I have put on weight." People told us their dietary preferences were met. One person told us they were a vegetarian and there was always vegetarian food prepared for them.

However, we found there was only one choice available each day on the menu. The cook told us they had previously had two meal options on the menu, however this had been stopped because the staff said they did not have time to go around and ask each person what they wanted. They also said they had recently had their food budget cut and there had previously been too much food waste. The cook told us the menu was based on people's known likes; however the menu had not been discussed with people to demonstrate their satisfaction with what had been offered. We discussed with the registered manager whether they would discuss with people if they would like to have more choice on the menu and they agreed to arrange a residents meeting where this would be discussed.

People's nutritional needs were identified and monitored as part of the care planning process. There was a list of people's likes, dislikes, preferences, allergies and dietary needs available in the kitchen. The cook had clear information as to who needed any specialist diets such as diabetic diets, what texture and consistency of foods people needed and who needed to have their meals fortified. The cook told us they attended the daily handover so they were aware and able to respond to people's changing needs. They commented that communication with care staff was, "Very good."

Staff told people what their meal was when they gave this to the person and people had aids to support them to eat independently such as plate guards.

We observed people being supported by staff to eat their meals in their room. People were assisted by staff in an unhurried way. During these observations staff ensured people were sat in an upright position and they explained to them what their meal was. People had access to a wide range of fluids throughout both days of the inspection, the temperature was very warm and staff made a conscious effort to encourage fluids and attempt to keep people cool.

People's health care was supported by staff and by other health professionals. One person told us, "They are very good at getting the doctor if you need them to." Relative's told us they were happy with the support the home offered with health appointments and they were kept up to date with the outcome of any appointments. One relative told us, "They arrange appointments when needed and I am always kept in the loop."

People's care records showed referrals had been made to appropriate health professionals when required. When a person had not been well, we saw that the relevant healthcare professional had been contacted to review their condition. This meant people's healthcare needs were being met.

Good

Is the service caring?

Our findings

People told us the staff at Burnham Lodge were kind and caring. Comments included; "I have been here about 12 months and I find it very good. The staff are brilliant, very kind. I'm alright, I'm happy. It's good here I can't fault it in any way", "I love it here, all the staff really are wonderful" and, "Oh yes they have looked after me well. They all look after me."

Relatives also commented positively about the staff. Comments included, "The staff are friendly and [name] is happy here" and, "The staff are absolutely wonderful, very caring." Throughout our inspection we observed staff interacting with people who lived at the home in a kind and caring way. There was a good relaxed rapport between people and staff.

People thought staff knew them well. One person said, "Oh yes, they know me well." Another commented, "Yes I think they know me well." Staff spoke positively about people and they were able to tell us about people's likes, dislikes and what was important to them. One staff member told us, "We know people well; it's a small home which means we are able to develop personal working relationships." Another commented, "They are like our family, we have a good relationship with the residents and their family." This meant people had developed positive relationships with the staff.

People had a document call a 'map of life' in their care plans. These were completed with the person and their families to record information relating to the person's life history including their previous occupations, family details, likes and dislikes. Information such as this is important when supporting people who might have dementia or memory loss.

People told us they were treated with dignity and respect. One person told us, "They always knock on my door and treat me with respect, when they help me in the hoist (equipment used to transfer a person) it is done very nicely they make sure I am comfortable." Another commented, "I think I'm treated with respect and dignity"

We observed staff treating people with dignity and respect. For example, ensuring they were on the same eye level as people when they were talking to them and knocking on bedroom doors before entering. Staff described how they ensured people had privacy and how their modesty was protected when providing personal care. For example, closing doors and curtains and explaining what they were doing. Each person had a sign on their bedroom door indicating when it was not appropriate for others to enter; we saw these were being used during the inspection to ensure people had privacy. We saw dignity was discussed as part of a staff meeting to raise awareness of good practice.

Staff recorded information about people at the end of each shift. We found the daily records made reference to people being, 'kept clean and dry' when referring to their personal care rather than recording the assistance provided. We discussed this with the registered manager who told us they would discuss the use of terminology with staff to ensure it promoted dignity and respect.

People chose what they wanted to do and how and where to spend their time. Some people chose to stay in their rooms; others chose to spend time in the lounges. One person told us, "I get up when I want, sometimes I choose to stay in my room and other days I will go in the conservatory."

We looked through a file containing a number of thank you cards from relatives. We saw positive comments from relatives and visitors giving feedback on the service. These included; "Sincere thank you for your kind and caring reception when we visit [name] and your welcome cups of tea", "A massive thank you for all the love, care and support you have given to Dad and us as a family over the last three years. Keep up the fantastic work that you do", "Thank you for looking after [name] in his final days and for the support you gave to us and his family, you all do an amazing job" and, "It has been a great comfort to us to know that Dad was so well cared for. Thank you for the wonderful care that Dad received."

People and their relatives were involved in decisions about their care and support including the care and support they would like to receive at the end of their lives. The home had recently been achieved the platinum status by the National Gold Standard Framework (GSF) for end of life care. This is a comprehensive quality assurance system which enables care homes to provide quality care to people nearing the end of their life.

People's care plans showed people and their relatives had been involved in decisions and were able to express their preferences about how care was delivered. Advanced care plans and information about people's wishes regarding resuscitation had been signed by people or their representatives to show they agreed with the plan in place.

People's visitors and relatives could visit at any time and they were made to feel welcome. One relative told us, "There is a nice homely atmosphere and we are always made to feel welcome." During our inspection we observed visitors coming to the home throughout the day, there was a visitors signing in book in the reception so the staff knew who was in the building in case of an emergency.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan that was personal to them. Care plans included detailed information relating to how people wanted to be supported with specific tasks such as personal care. However, the care plans lacked specific and detailed information about people's communication, social, emotional, spiritual and wellbeing needs. The care plans were focused on tasks rather than the individual and they did not include enough information for a new member of staff to support them. Some of the care plans we reviewed contained conflicting information.

For example, one person's moving and handling assessment stated they should have their 'call bell at hand'; however the care plan stated the person did not use their call bell. Another person's care plan stated they were living with dementia and had difficulty processing information. The care plan did not give any further information on how to support the person with their communication needs. Staff told us the person verbally communicated when they wanted to, and they were able to communicate if they didn't like something. However, the information relating to how staff supported the person was not included in their care plan.

Another person was cared for in their bed and relied on staff to support them with all of their care and social needs. The person was unable to verbally communicate and was unable to use their call bell to summon staff. Staff described how they regularly checked the person and how they were able to recognise if the person was happy, uncomfortable or upset. However, the person's care plan did not have a communication section to describe this important information. This meant the person's communication needs were not being accurately assessed, recorded and reviewed.

We looked at the person's daily records for a week and the records did not include details of any social activities, interactions or stimulation. The person's care plan did not include guidance for staff on how to support the person with social interaction and stimulation. We discussed this with the staff and they described how they "Chatted" to the person when they supporting them, however there were no records of these interactions. Where other people chose to remain in their bedrooms there was a lack of detailed information in the care plans to inform staff of how to prevent people from becoming socially isolated. We discussed this with the registered manager who told us they had identified staff were not regularly recording activities and interactions and they were already addressing this with the staff.

Another person's care plan stated they used to go to church, however there was limited information in the care plan place giving details about the person's spiritual needs and preferences. The same person's care plan stated they had emotional and psychological needs due to them living with Alzheimer's and having short term memory loss, the care plan gave no guidance to staff on how to support the person other than 'explaining the procedures you undertake'. This meant care and treatment was not being recorded in a plan of care to achieve the person's preferences and meet all of their needs.

The staff we spoke with were aware of people's preferences and explained how they supported them, however the information would not be available for a new member of staff to support the person. We discussed this with the registered manager and they confirmed they had a consistent and stable staff team

and did not use agency staff. The registered manager also told us all of the care plans and risk assessments would be reviewed to ensure they contained clear, accurate and relevant information relating to people's individual needs. They also showed us a new care plan format they were planning on using and they informed us were in the process of creating an action plan that would give timescales of when the new care plans would be in place.

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

People's need for occupation, stimulation, and activities was not fully assessed and planned for or consistently delivered. There was an activities co-ordinator who worked for two hours in the afternoons and they told us how they provided activities on a one to one and group basis. During the inspection we observed a number of people remained in their room and seemed to have little social stimulation apart from when personal care was performed. One person told us, "There is not enough stimulation, I have to stay in bed and I hate it. I would like to sit out and go into the lounge." We discussed this with the registered manager who told us the person had been assessed to have a new chair which would enable them to spend time out of their bed. However, this was unable to be achieved because they were unable to design the chair for the person to sit safely in it.

Staff told us they thought people would benefit from more activities and social stimulation. Comments included; "Hours for activities should be increased. We are aware that more could be done to provide stimulus for residents but there is only so much one person can do in two hours a day" and "We try to spend time with people but there is only so much you can do. I think there should be activities in the morning because in the afternoon they go to sleep." Staff had raised the need for more activity resources in a meeting with the provider in June 2017.

There was no structured timetable of regular in house activities. The activities coordinator tried hard to support people to engage in activities and people and their relatives told us they enjoyed the activities when they were held. However, with only two hours each day to support the 18 people living in the home it was not achievable for each person to have access to regular activities and stimulation that met their needs and preferences .

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

People who wished to move to the home had their care needs assessed to ensure the home was able to meet them. This assessment was then used to create the plan of care once the person had moved into the home. People and their relatives contributed to the assessment and planning of their care. People and their relatives told us they were happy the care plans reflected their needs. They also said they were kept up to date with any changes. One person commented; "I'm happy with my care plan." A relative said, "I am happy with the care plan and feel involved."

The activities coordinator told us, "What's nice about this home is they always get a cake, card and present on their birthday. They have Easter eggs, Mother's day and Father's day cards, a Christmas party and Christmas present. Three times a year the local church come here, Easter, Christmas and Harvest Festival, they bring a choir. "The provider arranged for a range of external entertainers and musicians to visit the service to provide entertainment. However, we saw there were only four visits planned for the month of August 2017.

Staff told us how one person had a monthly communion in the home from a visiting church. A relative told us how a local animal sanctuary had visited the home with animals for the people to pet; they said this had been a positive experience for their family member.

The registered manager was very visible in the home and had a good knowledge of each person. Throughout the day we saw the registered manager chatted with people in a very relaxed and friendly way which enabled people to share any worries or concerns. People and their relatives told us they felt confident about raising any concerns and they were confident staff and the registered manager would respond. One person told us, "If I was unhappy I would speak to [name of registered manager]." One relative told us, "I would talk to [name of registered manager] without a problem, they are approachable." Another relative said, "I know I could speak to any of the staff."

When people arrived at the home they were given information about the complaints process and who to speak with if they had any concerns. Complaints information was displayed in the home. The home had not received any formal complaints in the past year.

The provider had systems in place to receive feedback from people, their relatives and staff. We looked at the feedback from the surveys carried out in December 2016. In total, 13 questionnaires had been completed and returned with 93% of the respondents identified themselves as between 'satisfactory' and 'very happy' with the service they received at Burnham Lodge Nursing Home.

The registered manager told us they had not held any recent resident and relatives meetings, they told us however the provider had planned a meeting for September 2017. Regular meetings with the residents and relatives will enable them to make suggestions about décor, food, activities and other community issues. They also enable the staff to document, by way of minutes kept of the meetings, positive responses to people's ideas and suggestions. The registered manager told us this was something they were going to arrange regularly in the future.

Requires Improvement

Is the service well-led?

Our findings

There were a range of audit systems in place; however they were not always effective in identifying shortfalls in the service. For example, they had not identified the concerns relating to medicines, shortfalls in the Mental Capacity Act 2005 (MCA), lack of water temperature checks being completed or recorded by staff, lack of detailed risks assessments and where information was lacking from the care plans. Whilst the registered manager responded to the shortfalls we identified and put actions in place to remedy them during our inspection, the current governance systems in place had not identified them. This meant people were at increased risk of not receiving care to meet their needs.

The provider's employed an external agency to complete a quarterly audit of the service called the operational service review. This audit covered care plans, records, the MCA, catering, medicines, meetings and staff files. We viewed the audits from December 2016 and July 2017. The audit from December 2016 identified the care plans required more details, activities were not recorded, handwritten medicines administration records were not signed by two staff members and MCA assessments were required for individual decisions. During our inspection we found this system had been ineffective in ensuring improvements had been made because we found similar concerns during our inspection. The failure to identify shortfalls, or act on the shortfalls when identified by a third party professional placed the health, safety and welfare of people living in the service at risk.

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

There was a registered manager in post at Burnham Lodge Nursing Home. The registered manager was a registered nurse and they kept their skills and knowledge up to date by on-going training, attending forums and researching the internet. The registered manager was also expected to work day and night shifts in the home to cover staff when they were absent, when we asked they told us they were not able to book agency staff to cover these shifts because of the cost implications. We looked at the staffing rotas and noted on some weeks they had worked three night shifts as a nurse.

Staff told us the registered manager was approachable and accessible and they felt confident in raising concerns with them. The registered manager told us they had a commitment to openness and promoted an open door policy where staff could approach them with concerns. They said they regularly worked alongside staff observing their practice and giving them feedback to support their development and promote best practice.

Staff were very complimentary of the support they received from the registered manager. One staff member told us, "The manager is good, you can go to them with anything, they are so approachable and really good." Other comments included; "They are a fantastic manager in every respect, I can't fault them. I feel appreciated and have so much respect for them" and, "The manager is brilliant, easy to talk to and runs the home well."

Meetings were held for staff on how to address any issues and communicate any messages. Staff told us meetings were held regularly and they felt able to voice their opinions. One staff member told us, "We have staff meetings and can raise any concerns, I feel listened to." Another commented, "We have team meetings every couple of months, we can speak up and feel listened to." Meeting minutes demonstrated areas covered in the meetings included; supporting people with dignity, communication, record, keeping and working as a team. The provider had attended a staff meeting in June 2017 to listen to their views. This meant people were supported by staff who were able to voice their concerns and opinions and felt listened to.

Staff commented positively about the team culture at Burnham Lodge Nursing Home. Comments included; "We are a brilliant team, like a family we all get on really well and can tell each other if there are any concerns" and, "We are a nice team, it's a nice homely atmosphere." This meant people were supported by staff who were motivated and positive about their work.

The key aims of the service were described in a document called a 'Statement of Purpose'. One of the service's key aims was "Provide a secure, comfortable & homely environment where individuality of care and maintaining dignity is paramount." Staff told us the visions of the service were to; "To provide a homely feeling environment and the best possible care" and, "We are here to make people as happy and comfortable, it's their home." This meant staff were aware of and shared the vision for the service.

The service had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities. We used this information to monitor the service and ensured they responded appropriately to keep people safe.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of service users was not designed to meet all of their needs and preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The correct procedures were not always followed where service users lacked capacity to make decisions for themselves. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Areas of the premises were not clean and properly maintained. Regulation 15 (1)

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
Treatment of disease, disorder or injury	Care and treatment was not always provided in a safe way. Risks to service users were not always assessed and mitigated. Medicines were not always managed safely. Regulation 12 (1) (2).

The enforcement action we took:

We have issued a warning notice. They must become compliant by 13 October 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and safety of the services provided were not fully effective. Accurate and complete records were not kept in respect of all the care and treatment provided to service users. Regulation 17 (1) (2)

The enforcement action we took:

We have issued a warning notice. They must become compliant by 10 December 2017.