General Medicare Ltd

Burnham Lodge Nursing Home

Inspection report

147 Berrow Road
Burnham On Sea
Somerset
TA8 2PN

Tel: 01278783230
Website: WWW.BURNHAMLODGENURSINGHOME.CO.UK

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This inspection took place on 6 and 7 March 2018 and was unannounced.

We last undertook a comprehensive inspection at Burnham Lodge Nursing Home in August 2017. At this inspection in August 2017 we found the provider to be in breach five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 9, Person centred care, Regulation 11, Need for consent, Regulation 12, Safe care and treatment, Regulation 15, Premises and equipment, and Regulation 17, Good governance.

Following the inspection in August 2017, we served two Warning Notices for breaches in Regulations 12 and 17. In addition to this, we set requirement actions relating to breaches 9,12, and 15. We also asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well led to at least good. The provider told us they would make the required improvements by January 2018.

We undertook a focused inspection in December 2017 to check the provider was meeting the legal requirements for the two regulations they had breached that resulted in them being served Warning Notices. During the focused inspection we found the provider had taken action to ensure compliance with these regulations.

During this comprehensive inspection in March 2018 we found improvements had been made in some areas, we also found areas that still required improvement.

Burnham Lodge 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.

Burnham Lodge Nursing Home provides residential and nursing care for up to a maximum 23 people. At the time of our inspection, 19 people were living at the home. The home 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 told us they were happy with the food provided. Our observations of the mealtime experience were mixed, some improvements were required to ensure people had a choice of the meals provided.

Some improvements were still required to ensure people's rights were fully protected in line with the Mental

Capacity Act 2005.

Our observations of people's involvement in meaningful engagement was mixed; the registered manager had plans in place to improve this. Care plans still required further information to ensure they identified people's social, spiritual and wellbeing needs.

There were systems in place to assess, monitor and improve the quality and safety of the service provided. These systems were identifying where some improvements were required, however they did not identify all of the shortfalls we found. During this inspection we found some similar concerns to our previous comprehensive inspection.

People felt safe living at Burnham Lodge Nursing Home. People were supported by staff who knew how to recognise and report abuse. Recruitment procedures were in place to ensure staff employed were suitable for their role.

Where risks had been identified to people's safety, suitable measures were in place to reduce the identified risks. Staff were aware of people's risk assessments and guidelines.

Staff were recording incidents when they occurred, these were reviewed by the registered manager for any lessons to be learned.

Medicines were administered safely to people, and people were happy with how staff administered their medicines. Some improvements were required with recording of medicines that were applied topically to the skin.

We received mixed comments from people about the staffing levels in the home, our observations were that there were enough staff available to meet people's needs.

The home was clean and free of odours. There were systems in place to ensure people were protected from the risk of the spread of infection

Staff monitored people's health and well-being and made sure they had access to healthcare professionals according to their individual needs.

Staff told us they received supervision and felt supported in their role. Staff received a range of training to help them to meet people's needs.

People were supported by staff who were kind and caring. Staff treated people with respect and dignity.

People felt able to raise concerns with staff and the registered manager. Staff felt well supported by the registered manager and felt there was an open door policy to raise concerns.

There were systems in place to share information and seek people's and relatives views about the care and the running of the home.

We have made a recommendation about the service reviewing how the service support people in line with the Mental Capacity Act 2005.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's medicines were stored and administered safely. Some records of medicines that were applied to the skin were not consistently completed.

Risk's to people's safety were assessed and planned for.

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

Systems were in place to minimise the risk of infection.

There were sufficient staff available to meet people's assessed care and support needs.

Lessons were learnt and improvements were made when things went wrong.

Is the service effective?

Requires Improvement

Some aspects of the service were not fully effective.

Some improvements were required to ensure people's rights were fully protected in line with the Mental Capacity Act 2005.

People's mealtime experience was mixed.

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

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

People's healthcare needs were supported and met.

There were plans in place to ensure the premises fully met people's needs.

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 were supported by staff that treated them with kindness, respect and compassion.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Improvements were required to ensure people's social, spiritual and wellbeing needs were fully assessed and planned for.

People's care needs were assessed and planned for.

A complaints procedure was in place. People and their relatives told us they felt able to raise concerns with the staff and management.

People's choices and preferences around the care they wished to receive at the end of their life was discussed and recorded.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to monitor and improve the quality of the service for people were still not fully effective.

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

There were systems in place to ensure people and their relatives had an opportunity to provide feedback on the service.

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 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.

This inspection took place on 6 and 7 March 2018 and the first day was unannounced. The first day of the inspection was carried out by two adult social care inspectors, a specialist advisor who was a registered nurse and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by one adult social care inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that the provider completes to give some key information about the service, they tell us what they feel the service does well and the improvements they planned to make. We also reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we spoke with 10 people who lived at the home, one visitor and eight members of staff. Staff spoken with included registered nurses, care staff, activity coordinators, the chef and ancillary staff. The registered manager was also spoken with during the inspection.

Some people were unable to fully express themselves verbally due to their physical or mental frailty. We therefore spent time observing care practices throughout the home and carried out a Short Observational Framework for Inspection (SOFI) in one area. SOFI is a way of observing care to help us to understand the experience of people who could not talk to us.

We looked at a selection of records which related to individual care and the running of the home. These included six care and support plans, charts identifying how and when people had received support with eating, drinking and repositioning, four staff files, medication administration records, minutes of meetings, audits and action plans.

Good

Is the service safe?

Our findings

During our last comprehensive inspection in August 2017 we found where risks had been identified to people's safety, suitable control measures were not always in place to reduce the identified risks. We also found some of the care plans we reviewed included conflicting information for staff to follow, which put the safety of people at risk. During this inspection we found improvements had been made and where people were identified of being at risk, control measures were in place and staff were aware of, and following, these.

For example, where people required bedrails, there were assessments in place to identify their suitability and any risks the bedrails may present. Where it was deemed unsafe for one person to use bedrails we found this was clearly documented and staff were aware these should not be used. Bed rails were checked monthly by the registered manager to ensure they remained in good condition. We saw new bedrail covers had been purchased and put on the rails which ensured the risk of entrapment was reduced.

One person was at high risk of falls, we saw there were detailed guidelines in their care plan on how staff should support the person to remain safe. Whilst we found the related risk assessment did not include the full details of the control measures, staff had a good knowledge of the action they needed to take to reduce the likelihood of the person falling. Records demonstrated the number of falls the person had experienced had reduced.

During our last inspection we found where people had unexplained bruising or marks on their body, these were not always recorded and monitored by staff on body maps. 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. During this inspection we saw body maps were in use and reviewed to record the healing process. The staff we spoke with told us they checked people daily to note any marks or bruises and they said if there were any, they would report this to the nurse on duty.

When incidents and accidents occurred these were recorded. The registered manager told us they reviewed incidents to identify any themes and trends to prevent further incidents. They told us how they looked at where lessons could be learned and improvements made to people's care. For example, where one person had experienced a fall and it was identified they were not wearing good fitting footwear, this now formed part of the person's care plan. The staff we spoke with were aware of the need to check the persons footwear to ensure it was suitable and fitted well.

At our last inspection we found staff were not following people's guidelines in relation to observing them during their meals, where they were at risk of choking or aspirating. During this inspection we found staff were clear about the content of people's guidelines and the level of observation they should be carrying out. They told us since our last inspection an allocated staff member was identified on each shift to ensure the required observations were carried out. We saw this was recorded on the daily handover shift, they also confirmed they had all read the eating and drinking guidelines. We observed staff following these guidelines during our inspection in relation to the meals received, however on one occasion we noted a person's drink

was prepared at a thicker consistency than it was prescribed. We discussed this with the nurse who told us they would ensure staff were reminded about ensuring drinks were made at the correct consistency.

During our last comprehensive inspection we found some aspects of medicines management needed to be improved. At this inspection we found improvements had been made, however we found some areas that still required improvement.

People had individual Medicine Administration Records (MARs) that included an accurate record of the medicines people took. However, we found one person had a handwritten note stuck onto their MAR detailing a change to a dose of a medicine they were receiving. We found there was no indication of who wrote, instructed or witnessed this instruction and no evidence of the GP confirming the change. This meant there was a risk the person would not receive the correct dose of the medicine. We discussed this with the nurse who told us they would ensure this entry on the MAR would be clearly recorded with who instructed the change and the staff that witnessed the instruction.

People were happy with the way staff supported them with their medicines. Comments included, "Yes, I get them the same time every day", "Yes no worries" and "I once had a problem with them, I wasn't sure why I was taking a pill, they explained why and I was very satisfied with the answer."

We observed that when staff administered medicines they didn't rush people, and checked they had a drink to take them with. Where people required 'as and when' medicines we saw guidelines had been written instructing staff on when and how the medicines should be given.

Medicines were stored safely and securely in the home, including those that required additional security. The temperature of medicine storage areas were monitored to ensure it remained within the correct range. People received their medicines safely from registered nurses who received specific training to make sure their practice was safe. No one in the home was self-medicating.

Some people were prescribed medicines, such as creams or lotions. There were clear instructions for staff on when and where to apply these. However, their administration records had not always been signed by staff to indicate that they had been applied. For example, one person was prescribed a cream to be applied to the skin two to three times a day; the records indicated that it had not been applied for any days in March 2018. Another person was prescribed two creams to be applied one to two times a day; we found the records indicated these had been administered on two occasions in March 2018. This meant there was a risk that people did not always have creams and lotions applied as prescribed, however we noted at the time of our inspection no one in the home had any pressure areas. We discussed this with the nurse who told us they would ensure staff completed the records once they had applied the creams.

During our last comprehensive inspection we found they were not suitable arrangements in place to ensure the premises were clean. We found areas of the home were dirty. During this inspection we found improvements had been made, the home was clean and free of any odours. The provider employed housekeeping staff to maintain a clean home. The housekeeping staff had a cleaning schedule which they showed us and they confirmed they had access to suitable cleaning products.
There were systems in place to ensure people were protected from the risk of the spread of infection. Staff had access to, and wore, personal protective equipment such as disposable gloves and aprons which also helped to minimise risks to people.

People told us they felt safe at Burnham Lodge Nursing Home. Comments included; "Yes I do feel safe", "Very safe indeed", "I could not feel safer" and "Very safe." A relative confirmed they though their family

member was safe, commenting, "I have to say I feel [name] is extremely safe here."

People were supported by staff who knew 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, "Any issues we all know where to go and what to do."

The home had a policy which staff were aware of and there was information about safeguarding and whistleblowing available for staff. One staff member told us, "I would go straight to CQC if I needed to." Another commented, "I am confident [name of registered manager] would take the right action, I've never had to report anything. I'm definitely confident to use the whistleblowing policy."

We received mixed comments from people about the staffing levels in the home, some people felt staff were a bit rushed at times. Comments included; "I think there could be more of them on shift" and "One or two more would be nice, they are so busy."

Staff told us there were enough staff available on shift and where there were shifts that needed covering, when a staff member was sick for example, these were always covered. Comments from staff included; "Staffing is very good, we have enough staff, more than ever. There are always four carers and one nurse on each shift", "Staffing levels are good, shifts are covered and there are enough staff" and "Staffing is ok, there are enough."

During both days of the inspection we observed staff were visible and call bells were answered swiftly. The registered manager told us they used a tool to assess the numbers of staff that were required. We reviewed staffing rotas and noted the identified staffing levels were consistently met.

At our last inspection we found risks to legionella bacteria in the water systems were not being managed consistently. Water temperatures were not being consistently tested to ensure they remained within a safe temperature range. During this inspection we found improvements had been made. Regular water temperatures were completed and recorded, the home had a recent legionella test completed on the water system that confirmed no legionella bacteria was present.
There were a range of other checks in place to ensure the environment and equipment in the home was safe. These included a fire risk assessment, testing of the fire alarm system, electrical equipment checks and the passenger lift. The home had a crisis contingency plan, which the registered manager told us had been used successfully in the recent bad weather.

Recruitment procedures were in place to ensure staff employed were suitable for their role. Staff had to attend a face to face interview and provide documents to confirm their identity. Staff also had a range of checks completed before they were allowed to support people, these included previous employment references and checks by the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people. We noted one staff member's application form included gaps in their employment history that had not been explored. Having unexplored gaps in employment could impact on the provider's ability to ensure a staff member's suitability to work with vulnerable adults. We discussed this with the registered manager who confirmed they would explore and record the reasons for the gaps.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection we found 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.

During this inspection we found some improvements were still required to ensure full compliance with the MCA. For example, where one person lacked capacity to make certain decisions; such as having bedrails in place and wearing specific clothing to protect them from harm, we found there were individual best interest decisions in place for this, however only one mental capacity assessment had been completed to cover all of these decisions. Another person had a mental capacity assessment that covered various areas of their support, for example, risk of falls and all their nursing needs, however it was not clear what the specific decision that needed to be made was. The person had a best interest decision in place for the use of a movement sensor mat in their bedroom and we saw the relevant people had been involved in this decision. We discussed this with the registered manager who told us they had arranged for further training in the MCA to support them to ensure the correct procedures were followed where people lacked the capacity to make specific decisions.

We recommend that the service revisits guidance relating to the Mental Capacity Act 2005 in relation to supporting people to make decisions.

Despite this the staff we spoke with had a good knowledge of the MCA. One staff member told us, "We had a situation where a person was diabetic and chose to have sugar in their tea, we advised them to have sweeteners but they had capacity so that was their decision. " People also confirmed staff asked for their consent before supporting them. Comments included, "Yes they do", "They do, yes" and "Nice and polite when they ask me too." Throughout our inspection we observed staff asking for people's consent prior to supporting them.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had an understanding of the Mental Capacity Act and worked in partnership with relevant authorities to make sure people's rights were protected. The registered manager had made 14 DoLS applications to the local authority for people where required and they were waiting for the outcome of these.
People told us they were happy with the food provided; however we received mixed comments about the

level of choice they had over their meals. Comments included; "We just get what we are given", "Not really, but the food is very nice", "If we don't like the main meal we can have a sandwich or a jacket potato", "I don't think we get much choice", "More variety would be nice, the food we get is lovely though" and "It is great food, tastes wonderful."

We observed lunch on the first day of our inspection and our observation of the mealtime experience was mixed. A majority of people ate their dinner in the lounge/conservatory area, where they had been sat during the morning and had tables pulled up to their chairs, rather that sitting up at a table to eat their meals, which prevented people from having a sociable mealtime experience. One staff member told us, "They did sit together at the dining table for Christmas, they all seemed to like it, it was lovely."

We saw people were given their plated meal and although people appeared happy with the food, there was only one option on the menu and no system in place for checking that everyone was happy to have the meal prior to them receiving it.

We saw occasions where meals were placed in front of people without staff informing them what their meal was. We observed only one person had access to condiments such as salt, because they were able to ask for this, other people who were not able to ask were not offered.

We also saw some examples of staff telling people what their lunchtime meal was, and people were not waiting for long periods of time to receive their meal. However, we observed one person was sat in their bedroom with their meal in front of them for 20 minutes before a staff member arrived, the person's care plan stated they needed "Prompting from staff." We observed a staff member supporting another person with their meal in their bedroom and noted there was limited communication, the staff member appeared to be watching the television rather interacting with the person they were supporting.

In addition to this on the second day of the inspection we observed the tea round being completed in the morning by the kitchen assistant. We observed they put a cup of tea in front of people without checking if that was the drink they wanted and they gave people biscuits rather than offering a choice. Another care staff member intervened when one person was given tea, informing the kitchen assistant the person had requested a glass of milk rather than a hot drink, which they subsequently received.

We discussed this with the registered manager who told us they had tried offering two meals at lunchtime, but this had not been a success and there had been lots of food waste due to people choosing the same meals. They told us however they would introduce a system for the kitchen staff to check each morning if people were happy with the option on the menu and offer alternatives if they were not. The registered manager also told us there were plans to use the second conservatory for people to dine in if they chose, they were waiting for the provider to ensure the room was suitable and safe for use before arranging this.

People were supported to maintain a healthy diet and people who were at risk of malnutrition were assessed and monitored by staff where required. Where one person had been identified as losing weight the staff had been very proactive in seeking health professional input and the person had a specific dietary plan in place. The cook was aware of the people who required additional calorie intake to ensure they maintained weight. The cook also had a list of people's likes, dislikes, dietary needs and preferences in the kitchen.

We observed people had access to drinks in the communal areas and in their bedrooms. We observed care staff encouraging people to have a choice of drinks throughout the inspection to ensure they remained sufficiently hydrated.

Some people were having their fluid intake monitored. The amount of fluid people required was not documented in care plans or on fluid charts. This meant it would not be easy for staff to know whether people were meeting their targets or not. We discussed this with the nurse who told us they would ensure this information was documented.

People and their relatives thought staff had the rights skills and knowledge to support them. Comments from people included; "I came in with an injury to my leg, they were very good with that, I felt very well looked after" and "They [staff] meet my needs." A relative told us, "All the staff seem very competent and really look after [name]."

Staff told us they received an induction when they started working in the home and they commented positively about it. One staff member told us, "I did some training and shadowing, they made sure I was ok and it was enough for me." Another commented, "We did shadow shifts and training before we could work alone, you could always ask for more but it was fine." 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 told us they had one to one supervisions (meetings with their line manager to discuss their work) and they found them supportive. Records confirmed supervisions were held. One staff member told us, "I have supervision every couple of months or if I request sooner, they are very good if we have any concerns they help." The registered manager also completed annual appraisal meetings with staff to discuss and provide feedback about their performance.

Staff told us they felt they had enough training to keep people safe and meet their needs. One staff member told us, "The training is ok. If we ask for training we get it in any subject we think is relevant." Another commented, "The training is good since I've been here." All care staff had been supported to gain relevant health and social care qualifications.

We looked at the training records which evidenced all staff received basic training such as safeguarding, first aid, moving and handling and infection control. Staff had also received training in dementia, equality and diversity and end of life care. The manager told us they were arranging for staff to attend further training in the MCA.
People told us they were happy with the support they received to access health professionals. Comments Included; "I was ill a few weeks ago, I told the nurse and they had a GP out to me sharpish" and "Yes I see the GP when I want to." A relative told us, "I believe the family receive regular communication from the home and as far as I know are very happy with all the health care [name] receives."

People's care records showed referrals had been made to appropriate health professionals when required. These included the chiropodist, optician, dietician and doctor. 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 and they received on-going healthcare support.

During our last inspection we identified concerns relating to the environment. 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. Since our last inspection some work had been carried out to replace some of the carpets and we noted some areas still required improvement. The registered manager told us there were on-going plans to further improve the environment and equipment in the home.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Throughout both days of the inspection we saw staff spoke with people respectfully and showed kindness and patience when supporting them. When staff supported people to move around the home, they did not rush people and offered encouragement and reassurance where appropriate.

People told us the staff working at Burnham Lodge Nursing Home were kind and caring. Comments included; "Very, very caring", "So caring", "I do think they care for me very much" and "I feel like they care, they sit with me and chat, that's all I want." People also told us they felt they had a good relationship with the staff. One person said, "They feel like family", "I couldn't ask for a nicer relationship them", "It's a nice friendship I have with them" and "A lovely relationship."

Staff spoke positively about people; they demonstrated empathy and were able to tell us about people's likes, dislikes and what was important to them.
People had a document called 'This is me' in their care plans. These were used 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. The staff we spoke with had a good knowledge of the people they were supporting.

When asked if staff respected their privacy and dignity, people confirmed they felt they did. One person told us, "I like to think they do." Other comments included; "Yes they do, they treat me as a person", "I feel like they do", "Yes" and "Very much so."

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. One person confirmed this stating, "They are very polite always talking to me when they help me." We observed staff supported people discreetly when they required support with personal care.

Staff also described how they discussed dignity and respect in staff meetings. One staff member had been designated as the "Dignity Champion." This role involved promoting reflective practice and learning around the subject of dignity within the team. The dignity champion told us this happened in staff meetings and involved them reflecting on a specific issue that could improve the dignity of the people living in the home. They gave us an example of how staff noticed they did not always wait for a response when knocking on people's bedroom doors to confirm it was ok to enter. They confirmed this was something they now did, due to this reflective practice. Minutes of the dignity meetings documented a discussion had been held around supporting people living with dementia with personal care, when they may become confused and anxious. Different approaches to this were discussed within the team and recorded.

We found however some care records did not always demonstrate the support people were receiving was referred to in a personalised way. For example, we looked at the records of the support people had received and these referred to people "Being kept clean and dry." We discussed this with the registered manager who

told us they would ensure staff recorded information in a more personalised way.

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. Relatives were kept informed about any changes and were involved in decisions where people were unable to fully express their views. People were able to see visitors when they wished. There were relatives and friends visiting people in the home during the inspection.

We saw feedback cards from relatives to the manager and staff team giving positive comments about the staff. Comments included, "Thank you for all the loving care provide all year round" and "Thank you for all the care you gave [name of person]. They enjoyed their time with you and had a good word for all the staff. Everyone gave their time to have a nice chat with [name of person]."

Requires Improvement

Is the service responsive?

Our findings

During our last comprehensive inspection we found people's 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.

During this inspection we found some improvements had been made. For example, where one person was unable to verbally communicate, details of how they communicated was recorded in their care plan and staff were aware of this. Each person also had a one page profile of their life history, family, past interests and hobbies.

However, the care plans in relation to people's social, emotional and spiritual needs still required some improvement. For example, we reviewed one person's care plan who spent time being supported in their bed. Whilst the care plan had a document that gave details of their past interests, we found there was no subsequent care plan in place detailing how staff should support them with this. We discussed the person with one member of staff who told us of the person's past interests, and how they put on specific TV programmes that involved these. However, this wasn't consistently fed back to us by staff. We reviewed the person's record of activities and this wasn't completed consistently with some entries lacking details, for example, "Conversation whilst giving pc (personal care)" and "Cutting nails and [name] responded with a smile."

Staff told us another person preferred a specific type of music and they relied on staff to support them to put his on in their bedroom. Whilst we observed this being on in the person's bedroom whilst they were in bed, there was no specific care plan instructing staff this was the person's preference.

Some aspects of people's care and support was not being recorded. For example, one person required oxygen, whilst the nurse told us the equipment for using this was regularly changed, there was no record of this.

Another person had a specific care plan in place detailing how staff should position them because their muscles were contracting causing them to become stiff and have limited movement. The plan stated they should have an item in their hand and one between their knees to support them. Staff told us the person regularly refused to have the items placed in their hand and between their knees, however there was no record of when this was attempted and if the person had refused. This meant we were unable to ascertain if the care plan had been followed.

Care plans included detailed information about the care people required. For example, they detailed the support people required with their personal care and that they should be given a choice of toiletries, whether they wanted a bath or shower, for staff to encourage people to be involved and their preferred gender of staff to support them. People's toiletries preferences however had not always been documented.

We discussed the lack of some information in the care plans with the registered manager and they told us they were aware this was still an area that needed work and their action plan and audits confirmed this was still on-going. They told us since the last inspection they had focused on getting the basis of the care plans completed and the next stage was for them to develop the social, emotional, spiritual and wellbeing aspect of these.

Where people were able to they were involved in reviewing their care plans, and where they were not we saw their representatives were involved. One person told us, "I've never had a reason to want to change it."

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 prevent the risk of people developing pressure ulcers. We looked at the mattress settings and noted four were not set at the correct pressure. We noted however no one in the home had any pressure ulcers. We discussed this with the registered manager who told us they completed weekly audits of the mattresses settings. We reviewed the last audit completed in February 2018 and noted not all of the records of what the settings should be were correct. Following our inspection the registered manager confirmed these had been amended to reflect the correct settings.

At our last comprehensive inspection we found people's need for occupation, stimulation, and activities was not fully assessed and planned for or consistently delivered. During this inspection we found some improvements had been made, and the registered manager told us there were further improvements planned.

People told us they were happy with the activities on offer, however, our observations of people engaging in meaningful activities and occupation during our inspection were mixed. For example, on the first day of our inspection the activity coordinator was making Easter cards with people, however we noted on several occasions they were requested to support people with personal care as they had also worked in the home as a carer. During the morning of the second day of the inspection people were sat in the lounge and the television was on. Not everyone could see the television due to their position in the room and we observed people falling asleep. Only one person was able to mobilise themselves. Staff confirmed people could be sat in the same position all day. When staff entered the room they spoke to people and engaged positively and we acknowledged one of the activity coordinators was on holiday the week of the inspection. We discussed this with the registered manager who told us since our last inspection they had attempted to rearrange the layout of the lounge to make it more sociable and people had requested to go back to their usual seating positions.

There were two activity coordinators employed by the home who offered a range of activities for people to take part in if they wished to. Activities included; external entertainment groups, local animal sanctuaries visiting as well as in house activities such as quizzes, arts and crafts, manicures, pedicures, hand massages. The activity coordinator told us they also offered one to one sessions for people who chose to stay in their bedrooms and did not want to engage in group activities.
The registered manager also told us the activities coordinators had arranged planned activities for people such as, flower arranging and pancake tossing, we saw photographs of people enjoying this. The registered manager also told us the activity coordinators had plans to utilise the second conservatory once the provider had arranged to finish the work required to enable people to use it, to support people to be able to enjoy another environment if they wished.

Staff told us how they sat and chatted to people and one staff member commented how they supported a person to the hairdresser's room regularly to wash and style their hair because they enjoyed this. People

were supported to stay in touch with friends and family to promote their emotional well-being. People were able to follow their religious and spiritual beliefs because religious services were held at the home where people wanted this.

People could be assured that at the end of their life they would receive care that was compassionate and ensured their comfort. The home had 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.

Care plans described people's wishes for where they wanted to die and whether they wanted to be admitted to hospital in an emergency. People's spiritual preferences, if any, were documented. We saw written comments from relatives of people who had died at the home and they were very complimentary about the care people had received. These included, "All staff were understanding and compassionate at all times" and "Such a professional team at all times, we were always made to feel welcome."

The registered manager was very visible in the home and had a good knowledge of each person. People said they would feel comfortable raising a concern if they needed to. One person told us, "I have never had to, but I would just go straight to a nurse." Other comments included; "I would go to the manager and I would feel comfortable", "I would tell [my relative] or the nurse" and "Yes I would tell the manager and I would feel comfortable." The home had received no complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection we found the systems in place to monitor the service were not fully effective at identifying shortfalls in the service. During this inspection we found some improvements were still needed to ensure the quality assurance systems were fully effective.

The registered manager carried out a range of audits on the home, these included medicines audits and the care plans. Since our last comprehensive inspection additional audits had been put in place by the registered manager. These included bedrail audits, wheelchair checks, mattress audits and health and safety audits. The provider also employed an external agency to complete an audit of the service called the operational service review. This audit covered care plans, records, the Mental Capacity Act 2005 (MCA), catering, medicines, meetings and staff files.

We reviewed the audits and found they were identifying some areas where improvements were required. For example, the audit carried out by an external agency had identified the care plan updates were still on-going and the mental capacity assessments required more detail. The audit also identified other areas for improvement such as areas including the laundry required a deep clean and sensory items should be introduced for people with limited mobility. However whilst some improvements had been made, during this inspection we found some similar concerns to the comprehensive inspection in August 2017. For example, mattress settings were still not all accurate, the care plans required more details and there were still some shortfalls in the application of the MCA. Additionally the provider's action plan stated the required improvements would be made by January 2018. This meant the systems in place to monitor and improve the quality and safety of the service were still not fully effective.

There was a registered manager in post at Burnham Lodge Nursing Home. The registered manager told us since our last comprehensive inspection in August 2017 they were working less shifts as a nurse and had more time to focus on the management of the home. They showed us their action plan which noted the progress they had made since the last inspection and they were confident they had the right support and resources to ensure the required improvements would be made.

The registered manager was a registered nurse and they kept their skills and knowledge up to date by on-going training and attending forums and meetings with other managers to share experiences and good practice. The registered manager maintained a regular presence in the home and they had a good knowledge of the people and the staff who supported them. They spent time in all areas of the home which enabled them to constantly monitor standards.

People knew who the registered manager was, they spoke highly of them and confirmed they saw them around the home. One person told us, "I do know who she is, she is very lovely'." Other comments included; "Oh yes, she is always coming round and chatting to me", "She is a wonderful person", "I see her now and then, she seems very competent" and "She is a great manager, I think she is fantastic."

Staff also spoke highly of the registered manager. Comments included; "[Name of registered manager] is

brilliant, they are very approachable", "[Name of registered manager's] door is always open, they are good, friendly and fair to us all" and "[Name of registered manager] is very supportive and easy to approach, anything you need to discuss they are always here."

Staff meetings were held which were used to address any issues and communicate messages to staff. One staff member told us, "I feel listened to, we have regular staff meetings where we all get to say our bit." Another commented, "We have regular meetings where things are aired, if we are not happy about something we are able to say something." Records demonstrated areas covered in the meetings included; team culture, the environment, responsibilities, equality and diversity and an open discussion for staff to raise anything they wished.

There were systems in place for people and their relatives to provide feedback on the service. These included twice yearly residents meetings and annual satisfaction surveys. The provider attended the last residents meeting in September 2017 and the meeting minutes demonstrated they asked people and their relatives for feedback. We saw the feedback that was received about the home, registered manager and staff was all positive. The registered manager told us they were about to send the satisfaction surveys to people and relatives. The last survey was carried out in December 2016 and the results of this was that 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 their aim for the service was for people living at the home to be happy and well looked after and for Burnham Lodge Nursing Home to be their home. Staff understood the values of the organisation. One member of staff said, "We aim to provide the best possible care for the residents, we are all here for the same reason and this is their home." Another commented, "We want to create a friendly, safe and homely environment. A home from home."
The home had links with the local community such as; visiting churches, local charities, local bands and preschools. The registered manager also told us how they arranged visits to local garden centres and seaside towns.

The registered manager 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.