Burnham Lodge Limited

Burnham Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Burnham Lodge is a nursing care home providing accommodation for a maximum of 60 people. At the time of the inspection 31 people were using the service which is operated from a large stately home set in vast acreage. Four floors offer bedrooms and facilities, including large communal dining areas, an activities room based in the conservatory and a large day room. Each bedroom has an en-suite with additional toileting and bathing facilities offered per floor.

People's experience of using this service and what we found
We found risks to people using the service were not always clearly identified and managed. We also identified concerns in relation to the safe management of medicines. We made a recommendation in relation to systems in place to identify and respond to safeguarding concerns. People indicated they felt safe, with comments including, "I do feel safe here, the staff are sensible" and "Yes, I always feel safe living here, I am being looked after very well as far as I'm concerned."

Staff were safely recruited. We observed positive interactions between staff and people, with some examples of less person-centred care also observed. The service utilised technology, providing staff with hand-held devices with access to people's care plans, details of care tasks required, and a link to alerts from movement sensors and call bells.

Some people felt they would benefit from improved staffing continuity. People's comments included, "Some of the carers are very kind and helpful, the carers do change all the time, sometimes it feels like they are never the same for long" and "Some of the staff are absolutely amazing here, although we rarely have conversations, those we have are always short… they simply haven't got the time." A relative also commented, "Generally the staff are very good, but she doesn't like being washed by strangers…if she had regular staff it would make a difference to her." A second relative commented, "I have no major concerns but he is not stimulated...it's a fairly quiet atmosphere, some residents seem cheerful."

We received positive feedback regarding the service's environment. A relative commented, "The atmosphere is nice, they have amazing gardens and it feels like home." Other comments from relatives included, "It's very homely, friendly" and "They get tea and coffee throughout the day. The ambience is good, and the building warm and nicely furnished with a big TV."

Systems were in place to monitor the quality and safety of the service, however these were not always fully effective and we found some gaps in recording, such as records used to document support given with personal and oral care. The service planned additional staff training to help improve documentation.

Systems were in place to engage with people and their relatives. Some relatives raised concerns regarding the accessibility of communication with the service, with particular difficulties in making telephone contact. Comments from relatives included, "[Registered manager's name] always provides me with updates", "The

manager is okay, approachable, accessible and will get others to sort stuff out and then let me know" and "There was nothing before but recently they started having [relative] meetings…There was a couple of issues initially and I think they were acted upon but I did not get feedback." The telephone system was due to be replaced.

People were generally supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 09 January 2020).

Why we inspected
We received concerns in relation to an increased number of falls resulting in injury and concerns expressed from families in relation to the quality of people's care and communication with the service. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Burnham Lodge on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safe care and treatment and in informing the Commission of information they are required to.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect

sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Burnham Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector and one Expert by Experience, with remote telephone support from an additional two Experts 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.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with thirteen people using the service, eight of whom were able to give us their opinions about the service. We also spoke with 24 relatives and 19 members of staff including seven care assistants, a laundry assistant, a servery assistant, a chef, two nurses, a senior nurse, a maintenance staff, administrator, registered manager, regional support manager, quality director and the operations director who is appointed nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Some staff we spoke with were working at the service as agency staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed infection control and medicines practices, reviewed the environment and looked at 20 people's records on the electronic care plan system, either in full or in part. We looked at five staff recruitment and supervision files. We also examined a variety of other records including medicine records and cleaning schedules.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We looked at a range of records including audits, staff rotas, safeguarding records, meeting records, policies and procedures and staff training records. We received feedback from four professionals who had contact with the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● The provider did not do all that was reasonably practical to mitigate risks. This was because some people's risk assessments and care plans lacked accurate and personalised detail to inform staff about how to manage risks. One person had a history of showing physical distressed behaviours towards staff, however the care plan did not accurately describe the person's distress which included punching, biting and pinching staff. A staff member we spoke with believed their behaviours had been verbal only, informing us "[Person] gets quite cross and shouts." Another staff member described the person as "very aggressive", and the person was supported by two people, to help protect staff following a history of false allegations against staff.

● Oral hygiene records were poorly maintained. One person required support with dentures and mouth hygiene. Hygiene charts for October 2021 showed one date where oral care had been given and two dates where denture care was provided. Whilst staff we spoke with were aware of the person's needs, records did not adequately evidence the person received regular oral hygiene, and we noted the person had required treatment for oral thrush. The care plan highlighted the risks of poor oral hygiene, including risks of tooth pain, deteriorating gums and growths within the mouth. Another person's oral hygiene chart showed two instances of oral care during October 2021.

● One person had a diagnosis of Type II diabetes and their care plan included symptoms of hyperglycaemia and hypoglycaemia. We spoke with two staff who supported the person. One staff member had a limited awareness and advised they would observe for thirst and tiredness. The second staff member had no awareness of the potential symptoms. The person's care plan instructed nursing staff to take blood sugar readings three times per week, however records showed only seven blood sugar readings for the month of October 2021.

● Allergies were documented however some staff lacked knowledge about people's needs. One person had an intolerance to cow's milk. Medical records noted the allergy, stating there had been no documentation of reaction. The person's care plan identified they should not be given hot drinks containing cow's milk. A staff member supporting the person was not aware and described providing coffee using whole cow's milk.

● Concerns were identified in relation to the use of drink thickeners. One person required slightly thick fluids, however records contained several references to mildly and moderately thick fluids. We therefore were not fully assured the person consistently received fluids prepared to the correct consistency. Another person had been discharged from Speech and Language Therapy (SALT) as requiring mildly thick fluids. Care plans contained contradictory information, and a wall notice instructed staff to provide either slightly or mildly thick fluids. Some staff confirmed they provided slightly thick fluids. This meant the person could have been placed at risk as SALT recommendations had not been implemented.

● One person experienced a sequence of falls in July 2021. The care plan documented three unwitnessed

falls. Daily records included two subsequent incidents where the person had been found on the floor. A wound chart also showed a bruise to the person's eye and forehead. Records did not evidence the cause of bruising was fully investigated. The falls risk assessment was not updated in response to the two incidents where the person was found on the floor. Although some measures were in place to reduce the risk of falls, including a sensor mat, we were not satisfied the person's risk of falls had been robustly managed.

Risks to people were not clearly identified and managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service responded to our feedback and immediately updated staff regarding the person's milk intolerance, and people's requirements for thickener. We were advised an audit had identified staff recording of thickener use as an area for improvement and staff training had been booked. The service also planned to meet with nursing staff to review the use of wound charts to ensure relevant information was documented.

● At our last comprehensive inspection we found some staff had not received training to use fire evacuation equipment. At this inspection feedback and records showed staff received fire safety training and were shown how to use evacuation equipment. Maintenance staff provided evidence of fire drills and fire safety checks. We also reviewed evidence in relation to the safety of the premises, including gas, electric and water management.
● The service identified people at risk of dehydration and malnutrition. One person had lost a significant amount of weight following an admission to hospital. A weight loss care plan was implemented. The service commenced more frequent weight checks, staff kept records of food and fluids consumed, and the service requested input from a dietician and speech and language therapist.
● Some people were at very high risk of falls and several people had sustained fractures at the service within the last 12 months. Some people received one to one support due to a risk of falls. We observed sensor mats and crash mats placed next to people's beds and chairs. One person told us how their risk of falls was managed, advising, "I have a call button on my wrist...I'm here because I fell badly at home; they have given me a stick stand [walking aid]…they watch me and if I get to stand up they do not like it and tell me to sit down."

Using medicines safely
● We observed unsafe storage of thickeners and creams. Some creams did not have open date labelling, and the service did not provide evidence of a risk assessment in relation to the storage of creams in people's bedrooms in unlocked drawers or bathroom cupboards. We located thickeners in an unlocked wall cupboard and a chest of drawers. The registered manager believed the risk to people was low, however risk assessments for both individuals stated thickeners should be kept in locked storage due to the risk of choking from accidental ingestion.
● Records logged the daily minimum, actual and maximum temperature of the medicines fridge. Records showed the maximum temperature exceeded the safe range for medicines storage on seven occasions during October 2021. In some cases, fridge temperatures can rise when a fridge is opened for administering medicines or re-stocking. The fridge had been re-set, however where a temperature deviation had occurred, the service had not taken an additional temperature reading in the same day to ensure it was a transient deviation. The service's medicines policy stated this would be best practice. We requested the service make contact with the pharmacy to discuss the temperature readings. It was confirmed the medicines remained safe for use.
● Some care plans did not provide staff with sufficient instructions for the safe application of creams. Some care plans did not refer to the specific name of cream in use, or clearly specify the frequency of use and

required thickness of application. One person's care plan instructed staff to apply a cream which was no longer in use. Another person's care plan advised staff to "apply barrier cream if required", without outlining how staff would determine when the cream should be used. Some staff told us they applied barrier creams each time they changed incontinence pads and another staff member told us they only applied cream if private areas were sore or red.

We found evidence safe medicine practices were not promoted in relation to medicines storage and use of topical medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. Thickeners were immediately secured on the day of our inspection. Contact was made with the pharmacy to discuss the medicines fridge and it was confirmed medicines remained safe for use. People's care plans were updated to include additional information about the use of topical creams.

● Medicines taken orally were safely administered. We observed a nurse practicing hand hygiene and seeking people's consent before providing medicines support. The nurse checked the medicine administration record (MAR), cross referenced with the medicine label, and stock checked each medicine before administration. Medicines were kept secure within a locked medicines trolley.
● People received oral medicines from nursing staff whose competency had been assessed. Records showed competencies had been reviewed in relation to safe medicines storage and disposal, safe handling and administration of medicines, and correct documentation.

Preventing and controlling infection
● Procedures were in place to admit people safely to the service, however we were not satisfied these had been followed appropriately. In line with government guidance, the service's policy required staff to take people's temperatures twice daily, to identify signs of COVID-19. We reviewed records for two people who were isolating following hospital discharge. One person's daily notes and temperature chart showed eight temperature checks across a period of 10 days. Another person had one temperature check logged for a period of five days. Temperature charts for other people using the service also showed temperatures were not consistently taken twice daily, and some records showed the absence of temperature checks for several days. For example, one person's records showed a gap in temperature checks between 2 October 2021 and 10 October 2021.

Effective systems were not operated to assess people's temperatures twice daily to check for signs of COVID-19 infection, including people isolating on admission. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home environment was generally clean, we observed suitable supplies of cleaning products, and cleaning schedules were completed. On the first day of our inspection we found used aprons disposed of within general waste bins, instead of designated clinical waste bins. The service was responsive to our feedback and the aprons were removed.
● At the time of our inspection, the service was not supporting anyone with COVID-19. This meant staff and residents were not in isolation or cohorting, although procedures were in place should an outbreak occur. We observed variable ventilation in the communal conservatory when visiting the home on different days, although noted it was cold outside and the building was heated for people's comfort. Chairs within the shared conservatory were closely spaced in a row along each side of the room. The provider told us the service had not experienced COVID-19 for several months, and therefore measures such as social distancing

were subject to risk assessment. Some people were living with dementia and could not understand guidance in relation to social distancing. For one person receiving support, we observed staff prompting the person, to avoid them entering other people's rooms.

● The provider was preventing visitors from catching and spreading infections. We observed signage at building entrances, people were asked questions about symptoms of COVID-19, temperatures were taken, and facilities were in place for visitors to take a COVID-19 lateral flow test. On the first day of our inspection we were not asked the service's health screening questionnaire before entry, however we were required to show evidence of a negative COVID-19 test result and read the service's visitor code on arrival into the building. On subsequent visits we were also asked health screening questions to confirm we did not have symptoms of COVID-19.

● The service facilitated visits in a screened area, and some visits also took place in a separate lounge or in people's bedrooms, where people were cared for in bed. Garden visits had been offered during suitable weather, and some people were supported to use video-calls to communicate with family members. Visitors were asked to wear appropriate personal protective equipment (PPE).

● Records showed, and staff told us, they received testing for COVID-19. These included on-site lateral flow tests and weekly PCR tests. Agency staff confirmed they were able to access testing alongside permanent staff. The service also supported people using the service to be regularly tested for COVID-19. The service had failed to document mental capacity assessments in relation to COVID-19 testing which we have reported on within the Well-Led section of this report.

● The provider's infection prevention and control policy had been updated in response to COVID-19. This included a detailed checklist outlining measures for isolation and deep cleaning should a person develop symptoms, or receive a diagnosis, of COVID-19.

● The service had sufficient supplies of PPE and we observed staff wearing appropriate PPE during our inspection. Most staff had received training in relation to infection control. Training records identified three staff who had not received training, two of whom were new starters. Records also confirmed the induction process for agency staff included guidance around the safe use and disposal of PPE.

Systems and processes to safeguard people from the risk of abuse

● The service had failed to identify and report some incidents to the local authority safeguarding adults team as required. Incidents included an unexplained skin tear, an unwitnessed fall causing injury and an injury to a person allegedly caused by another person using the service. This meant the local authority were not notified of potential concerns in a timely manner, to enable the local authority to carry out relevant enquiries.

● Whilst most safeguarding concerns had been appropriately investigated, the service had not fully explored a skin tear as a potential safeguarding issue. We viewed the records for one person who was cared for in bed and was found to have an unexplained skin tear. Records documented, due to a language barrier, the person couldn't give an account of what had happened. The wound was photographed and dressed. Records did not evidence the incident had been fully investigated to try to identify the cause of the wound.

We recommend the service review their approach to ensure safeguarding systems manage safeguarding concerns promptly, using local safeguarding procedures whenever necessary.

The service was responsive to our feedback and submitted safeguarding referrals to the local authority. The deputy manager was asked to investigate the skin tear sustained by a person using the service.

● People told us they felt safe. One person commented, "I feel very safe indeed living here. I was not happy at home and this is much a more suitable environment for me." A second person told us, "Yes, I think I feel safe living here…I have not had a fall since I came here."

● The registered manager worked cooperatively with the local authority when undertaking safeguarding enquiries. We viewed examples of safeguarding reports which showed evidence of learning and actions taken to prevent a reoccurrence of similar incidents. During our inspection the registered manager and provider attended a meeting with the local authority to discuss the progress and outcomes of recent safeguarding concerns.
● Staff received training in relation to safeguarding adults, although refresher training was overdue for one member of staff and two staff were awaiting training. This included one new member of staff. Staff had access to safeguarding policies. Whilst not all staff were familiar with the term whistleblowing, staff understood their responsibility to raise safeguarding concerns and report poor practice.
● The provider had policies in place in relation to safeguarding and whistleblowing concerns. We found the safeguarding policy did not refer to all types of abuse identified in best practice guidance. The service was responsive to our feedback and informed us the policy had been amended following our inspection.

Learning lessons when things go wrong
● Staff understood their responsibility to report incidents of concern to the nurse on shift, however we identified some events had not been flagged as incidents, such as incidents of distressed behaviours directed towards other people using the service. Staff meeting records showed staff were updated about trends and themes to help improve safety within the service. Safeguarding records showed where changes were made to implement learning from incidents. For example, following a person's fall from the stairs an electronic door lock had been added to ensure people could not descend the stairs unassisted.
● The service experienced a rise in falls during June and July 2021. Falls analysis was completed and a group staff supervision was held to share required actions. These included responding to sensor equipment promptly, encouraging people to spend time in communal areas where there was greater supervision and ensuring sensor equipment was correctly placed. A further staff meeting in October 2021 stated a delayed response to sensor devices had been noticed, indicating further improvement was still required. Records showed an overall reduction of around 45 percent in the number of falls between July 2021 and September 2021, indicating some actions had been effective in reducing the amount of falls.
● We reviewed records relating to a safeguarding incident in March 2021 involving the omission of medicines. Following the incident, required actions included re-training for nursing staff. We spoke with a professional from the clinical commissioning group (CCG) who had supported with re-training. The professional explained the registered manager had been open about the incident and how it could have been avoided, requesting targeted training to ensure staff implemented learning. The professional advised, "Part of management of incident was to update training…asked me to focus on areas and signpost to resources. They are a proactive home."

Staffing and recruitment
● Safe recruitment procedures were in place. Staff completed an application form, attended for interview and preemployment checks were carried out. These included disclosure and barring checks (DBS), two references from previous employers, proof of identification (ID), and a medical questionnaire to confirm staff were fit to work, or identify any reasonable adjustments required. A structured induction process including regular supervision was in place.
● Systems were in place to determine safe staffing levels. A dependency tool was in use which considered the care needs of each person using the service. The registered manager documented a further analysis to evidence how staffing levels had been reached, considering factors such as the layout of the home, people receiving end of life support, and the need for staff to support with activities pending the recruitment of an activity co-ordinator. The registered manager told us the provider was supportive of their decisions about staffing numbers, adding, "Hartford Care would encourage to put up, not down."
● The service was working to recruit additional staff. The service 'block booked' agency staff to improve

consistency, and an agency induction process was in place. Some agency staff we spoke with had worked at the service for several months. Some relatives expressed concerns regarding continuity of staffing. Comments included, "They're always changing staff…she is getting personal care from someone she does not know…there used to be regular staff and she would like the same staff" and "I have concerns about the staffing levels…there are a lot of agency staff. He says he has to wait a long time if he needs the bathroom and sometimes he has accidents."

● The service utilised technology to assist in the deployment of staff. Each staff member had a hand-held device which could be used to access care plans and identify care tasks requiring completion. This technology was also used as part of daily handover processes. Staff told us they felt staffing levels were appropriate to enable them to complete essential tasks. We also observed staff from other departments deployed at lunch to assist people with eating and drinking.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. CQC had not received the required notification when a medicines error was identified in March 2021. This meant CQC could not assess the risk to people in a timely manner, and were not informed of enquiries being made by other agencies. The provider explained they believed the notification had been submitted in the registered manager's absence.
- The service failed to identify certain incidents which met the criteria for reporting as a safeguarding alert, and therefore had not made the required CQC notifications in relation to these incidents. The service had also failed to submit the required notification when Police attended the service in August 2021 to assess a person's injury.

Effective systems were not in place to identify or report incidents to CQC in accordance with requirements. This was a breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

The service was responsive to our feedback and retrospectively submitted the required notifications to CQC. We found other notifications had been submitted in accordance with requirements.

- The provider had failed to document mental capacity assessments (MCAs) and best interests decisions where people may be unable to consent to regular testing for COVID-19. We viewed examples of COVID-19 testing consent forms signed by the GP. The forms did not document whether people could consent to swab testing or whether it was appropriate for the decision to be discussed with any family representatives to ensure regular testing was in the person's best interests.
- Some people had motion sensors or sensor mat equipment in place due to a risk of falls. We identified the service had not completed MCAs for all individuals who may not be able to consent to the use of this equipment. This had already been identified as an area for improvement through provider auditing. We also found decision specific MCAs had not been recorded for one person receiving one to one support. A referral had been made for this person for a deprivation of liberty safeguards (DoLS) authorisation.

We recommend the service develop their approach to ensure the service records mental capacity assessments whenever this is appropriate, to robustly evidence where decisions have been taken in people's best interests.

The service was responsive to our feedback and confirmed MCAs and best interests decisions would be recorded in relation to COVID-19 testing. We also found examples of other MCAs which had been documented appropriately, such as in relation to the use of bed rails and for one person who was given medication covertly in their best interests.

● Auditing systems were in place to monitor the quality and safety of the service, however these had not been fully effective in identifying and rectifying all of the issues we found, such as storage of medicines. We viewed examples of audits including falls analysis, use of systems, pharmacy, care plan, medicines, infection control and the provider's oversight audit. The registered manager also had a daily walk-around process in place. The service submitted weekly status reports which enabled the provider's quality team to monitor areas such as weight loss management, hospital admissions, falls, pressure sores, safeguarding referrals and reviews.

● Whilst audits identified areas for improvement, we were not satisfied all outcomes had been effectively implemented. A care plan audit completed in April 2021 found oral hygiene was documented on only five of 28 days. At this inspection charts used to document hygiene and oral care were inconsistently completed. We also found gaps in charts used to check people's pressure relieving air mattresses were correctly functioning. In another example, medicines audits from August 2021 and October 2021 identified similar concerns regarding inconsistent stock balance recording for as and when required 'PRN' medicines. We were advised staff training had been booked to improve documentation.

● The registered manager demonstrated commitment to their own continued development and the provider told us they had successfully graduated from a leadership programme during 2021. The provider had systems in place to recognise staff success, including a 'Hartford Heroes' awards scheme. We spoke with a staff member who had been nominated for this award for their significant contribution to the service.

● Staff received constructive feedback to highlight areas for improvement. Group supervision and staff meeting records showed feedback covering a variety of topics, including use of sensor equipment, dress code, improving the dining experience, daily recording and taking an inventory of belongings when people moved into the service. Staff told us individual feedback was delivered respectfully, a staff member advising, "If I do something wrong, manager will come…if not wearing apron for example [whilst] serving [food]… would say quietly to remind [me]."

● The service had undertaken projects to enhance people's care. At our last inspection, the service had participated in a hydration project with the local clinical commissioning group which resulted in improved hydration. The service continued to follow structured drinks rounds, including foods high in water content. The service had worked to reduce the number of people using catheters following hospital discharge. A recent project had also reviewed care planning for people with diabetes and identified areas for improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff interactions were generally kind and respectful. We observed instances where staff sensitively supported people experiencing distress and used reassuring touch. We found some interactions did not promote a person-centred culture. These included staff entering rooms without knocking or announcing themselves, staff speaking across people eating in the dining area and periods of minimal interaction where staff were not proactive in engaging people. One person was seated underneath an open window and informed a staff member, "I'm a bit croaky, I'm cold and I want my cardigan." A staff member acknowledged the request but thirty minutes later had not assisted the person. On the second request staff responded reasonably promptly.

● People were generally satisfied with the service. Comments from people included, "It is a well-run home" and "Staff are friendly and respectful." Other comments included, "They are mostly good and one or two

have good humour" and "It varies here, some days there is nothing to look forward to but some days someone does something really nice and helpful." Compliments received included, "He really appreciates the care and kindness you showed" and "You all have treated her marvellously, she was clean, warm and comfortable."

● Daily records were primarily task focused, logging information such as food and drink consumed and personal care. Records contained limited information about how people engaged with activities to enrich and give pleasure to their day. Some records logged chats with staff, other residents, or activities such as watching TV or spending time in the lounge. We observed people in the lounge enjoying music from a visiting entertainer and some briefer activities organised by staff, such as a word game and throwing a ball. The service supplied an activities plan showing recent and upcoming activities, including visiting entertainment, manicures and bingo.

● People's cultural, religious and other protected characteristics were identified. We observed one person had prayer beads left within reach to enable them to follow their daily prayer routine. Another person was supported to attend virtual religious services. Each person's records also included a detailed sexuality care plan, outlining how the person liked to express themselves, considering areas such as choice of clothing, make-up preferences, hair and nail care, including facial hair.

● Communication with families was variable. A family member provided positive feedback, advising, "They phone me once a week to tell me how she is." Several relatives expressed concerns, with comments including, "Communication with relatives is a weak point…I had a call to say dad had fallen out of bed, but it was two days previous…I can ring all day and get no answer", "Particularly at weekends – no one will answer the phone" and "There is an issue with communication, they just say she is fine, I don't get any feedback." The service planned to replace the telephones and an admin role had been created to enhance administrative support.

● Staff told us the registered manager was a positive role model. A staff member highlighted the registered manager as a reason they re-joined the service, advising, "Something about [registered manager's name] drive and passion…one of the reasons I came to do my bit. People are fantastic as well…felt like coming back home…focus and determination against all odds." A second staff member added, "Manager really supportive…approachable as well if need anything…work as a team here."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The service had a duty of candour policy in place. We viewed examples of written duty of candour responses shared with family members. These records demonstrated the service had provided open and transparent feedback when incidents occurred. On another occasion the service had failed to provide a written account of a duty of candour incident, however a face to face meeting did take place with the family member to discuss the incident.

● Staff we spoke with demonstrated an understanding of duty of candour principles. A staff member told us their understanding, advising, "When you have to tell what exactly happened, telling truth to family or nurses." A second staff member added, "If done anything wrong, must tell senior on duty, make sure don't do again this mistake." A third staff member told us the duty of candour related to being "honest, open and transparent."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Systems were in place to engage with staff. Staff were able to provide feedback through team meetings, group supervisions, an annual survey, and direct contact with the management team, such as via daily handovers or daily head of department meetings. Staff told us they felt able to share feedback. A staff member advised, "Quite open platform if any concerns or feedback." A second staff member added, "If I

need to discuss something, can go to talk with [registered manager's name] or [senior nurse's name] or anyone."

● A recent staff survey had been completed by 22 members of staff. We viewed the analysis and action plan, which included plans to hold quarterly HR surgeries for staff, and monthly workshops. Staff meeting minutes showed the results of the survey had also been shared and discussed with the staff team.

● The registered manager gathered feedback as part of their daily contact with people using the service. The registered manager explained due to people's cognitive needs, it was more effective to seek feedback from people about their day, instead of holding formal residents meetings. The registered manager identified people would enjoy an option of wine with their meals, and this had been introduced. People's daily feedback regarding mealtimes was also sought and their comments were documented. One person had commented, "As expected, always on the spot lunch. Thanks for the wine."

● Systems were in place to seek feedback from families. We viewed the results of a relatives survey conducted in 2019, which had been completed by two relatives. At the time of our inspection, a survey had been distributed to family members, and the service was awaiting further responses. Relatives confirmed they had received the survey, although one relative felt the format could be improved, advising, "The questions required yes/no answers and I couldn't honestly answer 'yes' or 'no' to any of them…answer choices reflecting degree of satisfaction would give a better picture and my feelings are not reflected in the overall result."

● A relatives meeting was held on the day of our inspection. This provided family members with an opportunity to provide feedback and to receive updates about the service. Due to national restrictions, this was the first meeting since the start of the COVID-19 pandemic, and relatives were encouraged to consider becoming more involved in the running of the home. One relative had assisted in the interview process for a member of staff. Another relative had recently started seated exercise sessions for people using the service.

Working in partnership with others

● Professional feedback and written records indicated the service generally worked effectively in partnership with other organisations. The service had links with key organisations including GP, local authority, podiatry, dietician, speech and language therapy and tissue viability nurses.

● The service worked closely with the GP surgery. A doctor told us, "[There is] always a nurse, senior nurse available to walk around with me, and everything else seems to be getting done." A tissue viability nurse added, "When Burnham Lodge have concerns, they do contact in a timely manner, [are] welcoming, follow our advice and do everything they can in patients' best interest to heal or palliate [the] wound as required."

● Prior to the COVID-19 pandemic the service was actively involved in the local community and had links with organisations such as the local school. At this inspection we found continued links with the school, although due to COVID-19 restrictions, physical visits were not possible. There were also links with a local church to support people who wished to take communion.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Effective systems were not in place to identify or report incidents to CQC in accordance with requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not clearly identified and managed. We found evidence safe medicine practices were not promoted in relation to medicines storage and use of topical medicines. Effective systems were not operated to assess people's temperatures twice daily to check for signs of COVID-19 infection, including people isolating on admission.