Miss Amanda Sutherland

Burlington Care and Support Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people.

About the service
Burlington Care and Support Services, referred to as Burlington House, is a residential care home that provides personal care and support for up to 13 people with a learning disability. At the time of the inspection there were 10 people living at the service. Accommodation is provided over two floors within two separate but adjoining buildings.

People's experience of using this service and what we found
People told us they felt safe, they liked living at Burlington House and most relatives we spoke with did not raise any concerns about the care their loved ones received.

We found the service was not operating in accordance with the regulation and was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture and best practice guidance. This meant people were at risk of not receiving the care and support that promoted their wellbeing and protected them from harm.

Right support:
People were not always supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible and in their best interests. People were not involved in a meaningful way in the development of their care and support and information was not always provided in a way which met people's individual communication needs

Right care:
Care was not always provided in a person-centred way which promoted people's dignity, privacy or human rights. People's care and support plans were not always reflective of their range of needs, supported their aspirations, or promoted their wellbeing and enjoyment of life.

Right culture: The ethos, values and attitudes of managers did not always ensure people using the services were enabled to lead confident, inclusive and empowered lives. Staff understood their role in making sure that people were always put first, but care and support was not always tailored to their individual needs and preferences.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 14 December 2019). Following that inspection, the provider was asked to complete an action plan to show what they would do and by when the improvements would be made. At this inspection we found the provider remained in breach of regulations and has been rated requires improvement for the last four consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 Burlington Care and Support Services 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 will continue to monitor the service and will take further action if needed.

We have identified breaches in regulation in relation to safe care and treatment, recruitment, staffing, the need for consent, dignity and respect, person centred care, notifications of other incidents and governance.

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

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We will meet with the provider following this report being published and work with the 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Burlington Care and Support Services

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 Health and Social Care Act 2008.

Inspection team
The inspection team consisted of one adult social care inspector, a medicines inspector and an Expert by Experience who had consent to phone and gain feedback on the care provided by the service from people's relatives. 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
Burlington House 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.

Registered Manager
The registered provider is also the manager. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection took place on the 28 April, 05 and 10 May 2022, the first day was unannounced

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used information gathered as part of monitoring activity that took place on 22 March 2022 to help plan the inspection and inform our judgements. We reviewed the information we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority. We used this information to plan the inspection.

During the inspection
We spent time with and spoke with seven people living at the service, six relatives, four members of staff, two assistant managers and the registered provider / owner of Burlington Care and Support Services. To help us assess and understand how people's care needs were being met we reviewed six people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records, policies and procedures and we spoke with a representative from Torbay Council's Quality Assurance and Improvement Team (QAIT).

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

• Although some relatives told us they felt people were safe, our findings were that people were not safe as the provider had failed to take adequate steps to address concerns relating to the management and mitigation of risks. This meant service users, staff and others were exposed to the risk of avoidable harm.

• People were placed at risk of avoidable harm as staff did not have all the information they needed to meet people's needs safely. For example, one person had been admitted to the service in September 2021. This person did not have a pre-admission assessment, care plan or any assessment of risks associated with providing care and support. This potentially placed this person, staff and others at an increased risk of avoidable harm.

• Another person had been admitted to the service in August 2021. Staff said they did not have access to a care plan and were not provided with any guidance on how they should meet this person's support needs until April 2022 when a support plan was created. Senior managers told us the delay had been due to covering shifts. We found care records for this person indicated potential risks, none of which had been fully assessed or form part of this person's risk management plan and staff had not been provided with any guidance on how they should manage or mitigate these risks.

• Where risks had been identified, the provider could not demonstrate that enough action had been taken to mitigate those risks and keep people safe. For example, one person had been assessed at risk of falling, due to a history of falls. Staff were instructed to provide supervision when going up and down stairs. During the inspection we observed this person walking up and down the main staircase. At the time of the observation this person did not have one to one support or supervision from staff. The failure to ensure that staff followed the guidance written in the persons care plan exposed this person to the risk of avoidable harm.

• One person's pre-admission assessment highlighted that this person could at times of emotional distress present a risk of harm to themselves as well as others. This information did not form part of this person's care plan and there was no risk assessment in place to guide staff as to any actions they should take to keep this person, themselves and others safe. The failure to assess and mitigate these risks placed this person, staff and others at an increased risk of avoidable harm.

• One person's referral record identified they had been diagnosed with Epilepsy, although they had not experienced a recent seizure. There was no care plan or risk assessment in place regarding the management of this person's Epilepsy or seizure activity. Staff had not been provided with any guidance on how they should manage or mitigate these risks. When we asked, one of the managers told us they did not know this person had been diagnosed with Epilepsy.

• The provider failed to ensure people were protected from risks associated with their living environment and fire safety systems. Fire safety records showed routine checks on the services emergency lighting system had stopped taking place in January 2022. This meant the provider could not be assured emergency lighting

systems would work in the event of a fire.
• We reviewed the services fire risk assessment and found this had not been reviewed or updated since August 2019. This meant the service did not have in place a suitable system to ensure fire hazards had been identified, action taken to reduce the risks of those hazards causing harm, or suitable management arrangements in place to ensure service users' safety should a fire occur in accordance with the providers legal requirements.
• Where risks had been identified by staff, action had not always been taken to minimise or mitigate those risks and keep people safe. For example, in December 2021, a staff member identified the need for a window restrictor to be fitted to one person's window. At the time of this inspection five months later no action had been taken and the risk was still present. We discussed what we found with the provider who told us they had not been made aware of the risk and assured us this would be addressed.
• People told us they felt safe and relatives were confident that their loved ones were safe. One person said, "I do feel safe. I didn't feel safe before I lived here but now, I do." A relative said, very safe [person's name] care is fantastic. I couldn't be happier with it." Another said, "Concerns none whatsoever."
• Staff had received training and were able to tell us the correct action to take if they suspected people were at risk of abuse. The provider had clear policies and procedures in relation to safeguarding adults. However, these policies were not always followed. For example, we spoke with both assistant managers about a recent safeguarding referral. Information relating to the incident could not be found nor was it used to inform the person's care plan/risk assessment.
• Systems were either not in place or robust enough to demonstrate accidents and incidents were effectively monitored, reviewed or used as a learning opportunity.

The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or effectively managed. This placed people and staff at increased risk of avoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staffing and recruitment
• People were not always protected by safe recruitment practices.
• We looked at the recruitment information for two staff members. Whilst some recruitment checks had been carried out, others had not. For example, one staff file did not contain full employment history and the provider had failed to apply for a Disclosure and Barring Service check (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This meant the provider was unable to demonstrate they had followed a thorough recruitment process in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• We discussed what we found with the provider who assured us they had checked the staff members DBS status and agreed to send us confirmation. Following the inspection, we received the DBS check confirmation however, this was dated after the inspection.

The failure to establish and operate safe and effective recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• People's medicines were not always stored or managed safely.
• Medicines due to be returned to the pharmacy for safe disposal were not stored securely. For example, these medicines were stored in a place which could be accessed by all staff, visitors and people living at the service.
• Other medicines were stored securely, and temperatures were regularly monitored. However, in the

register for medicines needing extra security we found that when items were returned to the pharmacy they were not always signed out of the register. Staff had not identified that these items in the register were not on the premises.
• In most cases staff assessed the level of support each person needed with their medicines, and recorded consent to administer. However, this had not been completed for one person who had been living in the service for over six months.
• When people were prescribed medicines 'when required' there were protocols to guide staff when they might be needed. However, these lacked person-centred details, and did not always match with the printed instructions on the label or medicines administration chart. For example, one person who was prescribed a sedative medicine had a maximum dose written on the protocol which was higher than that prescribed.
• Staff received training in safe medicine administration. However, there was no formal system of checking staff competencies and no records to show these checks were regularly carried out.
• Staff were not aware of the 'STOMP' initiative (to stop over medication of people with a learning disability, autism or both).

The failure to manage people's medicines safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Regular medicines audits took place and we saw that some areas for improvement had been identified and new systems put in place. However, they had not identified where improvements were needed.

Preventing and controlling infection
• People were not protected from the risk and spread of infection.
• We were not assured the provider was doing everything possible to prevent people, visitors and staff from catching and spreading infections. Whilst the provider had in place procedures for visitors and staff entering the service, these were not always being followed. For example, On the first day of the inspection an assistant manager allowed the inspector to enter the service without checking their temperature, screen them for possible symptoms or potential exposure to COVID 19 or ask them to produce evidence of a recent LFD (lateral flow device) test.
• We were not assured that staff were using PPE effectively and safely. On the first day of our inspection we observed a senior member of staff was not wearing a suitable face mask. They told us they had not worn a face mask since October 2021 due to medical reasons. We discussed what we found with the provider who told us they had taken advice and had been advised by a healthcare professional that the staff member should wear a face mask. No action had been taken following this advice to reduce / mitigate the risk or transmission of COVID 19.
• We were assured that the provider's infection prevention and control policy was up to date, however this was not always being followed.

The failure to effectively manage risks relating to infection control and the transmission of COVID-19 is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was facilitating visits for people living in the home in accordance with the current guidance. Relatives we spoke with told us they had been able to visit their relations regularly.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were not always assessed before they started using the service.
• One person had moved into the service in September 2021, at the time of this inspection the person did not have in place a pre-admission assessment, a care plan or any assessment of risks associated with their needs or the provision of their care and support. Staff had not been provided with any information of what this person's needs were or provided with guidance on how they should meet those needs.
• Another person had moved into the service in August 2021, staff told us they did not have access to a care/support plan or provided with any guidance on how they should meet this person's care and support needs until April 2022, when a support plan was created.
• One person's pre-admission assessment identified they had epilepsy and potentially could place themselves, staff and others at risk by their actions during times of emotional distress. This information did not form part of this person's care and support plan and staff told us they had not been provided with any guidance to enable them to support this person effectively.

The providers failure to ensure that people's needs were assessed is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other people's needs had been assessed and the information was used to develop care and support plans.

Ensuring consent to care and treatment in line with law and guidance

At the two previous inspections in February and October 2019 we found people were not always supported to have maximum control over their lives and senior staff were not consistently applying the principals of The Mental Capacity Act 2005 (MCA). This was a breach of regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• People were not supported to make decisions about their care as staff did not fully understand their roles and responsibilities under the Mental Capacity Act 2005 (MCA) including Deprivation of Liberty Standards. For example, where restrictions had been placed on one person to keep them safe through the use of a lap belt, this was not recognised by staff as restrictive practice and the person's capacity to consent to these arrangements had not been considered nor had staff followed a best interests process.
• We reviewed a number of people's capacity assessments and found they had been poorly completed. For example, none of the MCA assessments contained any information about how people were being supported to understand, retain, weigh up or communicate their decision. Mental capacity assessments did not contain any details of the person's views/preferences or wishes, therefore there was no evidence of the involvement of the person in the process.
• Staff's lack of knowledge and understanding of the mental capacity act, had led to them undertaking Mental capacity assessments on service users whether they had capacity or not. This blanket approach combined with a failure to be person and decision-specific created a disempowering culture. For example, we discussed what we found with one of the services assistant managers who said, "I thought it was best just to carry out MCA assessments on everyone."

The providers continued failure to properly assess and record people's capacity and/or best interest decisions risked compromising people's rights. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection we found the providers failure to ensure staff had been provided with appropriate training and supervision potentially placed people and staff at risk. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 18.

• People and their relatives had confidence and spoke positively about the staff supporting them. The provider told us they had invested in a new training system and staff told us they had access to training and supervisions. However, the findings of our inspection demonstrated that staff support, and training was not effective.
• There was limited evidence available to demonstrate the providers oversight through supervision or appraisal of staff's work performance. During our discussions with managers and staff we found there were clear gaps in their knowledge for example in relation to the Mental Capacity Act 2005, risk management, infection prevention and control, fire and positive behavioural support. None of the staff we spoke with including the managers were aware of or able to describe the underpinning principles of Right support, right care, right culture guidance (choice, control, independence, inclusion) and how this might increase people's quality of life.
• The providers supervision policy stated, staff at Burlington House who supported people with a learning disability or autism, will be offered clinical supervision in addition to scheduled supervision. This was not in place and assistant managers was unaware of this until it was raised by the inspection team.

The failure to provide adequate support and training to staff in order to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Adapting service, design, decoration to meet people's needs
• Burlington House is set over two floors, within two separate but adjoining buildings. Following the inspection in January 2019, we issued a 'notice of decision' to impose a condition on the providers registration. This required the provider to establish a comprehensive refurbishment plan and provide the Care Quality Commission with monthly updates. The provider had failed to provide this information.
• At this inspection we found environmental improvements were still needed for example, carpets remained worn, frayed and heavily stained in places and in one area taped together; some walls needed painting and some equipment was not clean. We noted the lounge within the 'annex' where three people lived continued to be used as a storage area for people's personal belongings. Assistant managers told us they did not have a refurbishment plan in place.

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

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they enjoyed the food provided and could make decisions about what they ate and drank and when. One person showed us the menu and described how they had been involved in deciding what they would like to eat. Another told us how they liked to bake and during the inspection we saw they had made cupcakes. However, there was limited information within people's care and support plan about how staff could/should support people to develop their domestic/cooking skills or increase their independence.
• Mealtimes were flexible dependent upon what people were doing each day and people could help themselves freely to snacks or drinks throughout the day and night.
• Staff told us people were encouraged and supported to maintain a balanced healthy diet and staff had a good awareness of people's dietary needs and preferences and these were catered for.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People received support to manage their health and physical care needs and were encouraged to engage with a range of healthcare services.
• Staff supported people to attend appointments and care records described the advice provided by healthcare professionals such as district nurses, physiotherapists and GPs to ensure people's healthcare needs were well understood by staff. For example, one person required support with their mobility. Records showed staff were working closely with Torbay hospital, occupational therapist and external specialists.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
• People living at the service were encouraged to make some decisions about day to day matters such as food and clothing. Staff told us people were supported to express their views and were involved as far as possible in making decisions about the care and support provided. However, more work was needed to ensure people were truly involved and seen as partners in their care. Staff were not able to tell us how they were engaging people in understanding their rights, supporting them to have increased opportunities or make informed decisions.
• Although we observed many positive interactions between people and staff during the inspection. The language sometimes used by staff to describe their interactions with people did not always demonstrate a person-centred approach or show they were valued as equal partners in their care. For example, during the inspection we heard one person telling one of the assistant managers that they did not want to go on holiday to 'Butlins,' they wanted to go to 'Eastbourne' instead. The assistant manager replied, "It doesn't matter anyway because we don't have the staff to take you."
• Records showed another assistant manager had written an incident report form because the person had refused to follow their directions.
• Most people living at the service had a support plan which contained basic information about their support needs, likes and interests. However, these were often outdated and not being reviewed in line with people's changing needs.

The failure to ensure that people were supported and empowered to have choice and/or control over the way they were cared for is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People who wanted to share their views with us, said they like living at the service, and the staff were kind and friendly. One person said, "I didn't like where I used to live but I like it here." Another said, "I couldn't have got through [xxx] without the support of [staff member name]."
• Relatives and those acting on people's behalf told us they were able to express their views about the care and support provided.

Respecting and promoting people's privacy, dignity and independence
• People's basic human right to privacy and confidentiality was not always considered or respected by managers and staff. For example, following the previous inspection in October 2019 a decision had been

made to move the main office into the quiet lounge downstairs. This meant that one person had to go through the office to access their bedroom. Throughout the inspection staff shared private and confidential information about people and staff with inspectors, seemingly unaware that the person and staff at times were in this bedroom. Both assistant managers told us they had not fully considered the implications of having a person's bedroom within the office and how this might impact on the day to day running of the service.
• People's personal records were not kept secure and confidential as the door to the office could not be locked and was accessible to all the people living at the service staff and visitors.

The failure to ensure people were treated with privacy and dignity is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's support plans now contained more information about what each person could do for themselves, although they continued to be less clear about how people could/should be supported to develop their life skills and increase their independence.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

At the last inspection, we found people were at risk of not receiving care and support that was personalised and reflective of their needs because support plans lacked sufficient detail. This was a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

• People's care records contained more information about people's goals and future aspirations. However, more work was needed to ensure people's opportunities were not limited by their own life experience. For example, people's records contained details of short-term needs/wants and everyday activities that most people take for granted. Like buying things they wanted or needed, going out for a meal, watching TV or taking part in arts and crafts. Records contained limited information about any action that had or could be taken to encourage and support people to broaden their horizons, develop life skills or try new experiences.
• People were not being supported or empowered to have choice or control over the way they were cared for and as such were not truly part of the care planning process.
• Care and support records were not being regularly reviewed or updated. Where reviews had taken place there was no evidence to demonstrate that people were involved or show their views/wishes had been sought and used to inform their care and support.

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

• People's communication needs were not always being met.
• The service did not identify, record and meet the communication needs of all the people living at Burlington House.
• Support plans had not been developed in an accessible format, such as easy read or pictorial. For example, one person was keen to show us their support plan but said they did not know what it contained as they could not read it.

The providers failure to ensure each person had a care and support plan designed to achieve their needs, wishes and preferences and ensure staff provided person-centred care and support was a continued breach

of regulation 9 (Person centred care) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were supported and encouraged to maintain relationships with friends and family, and we saw during the inspection people who were able, could come and go without any restrictions.
• An assistant manager described how they were working with people and their care managers (Local authority) to ensure people were not socially isolated and had increased opportunities within the community for example, attending day centres or identifying opportunities for work experience. However, opportunities remained limited for most people living at the service. The provider told us increased opportunities very much depended on staffing and the funding allocated by the local authority and described how they were working with one care manager to prevent a reduction in one to one support/ funding.
• As well as trips out, staff described how they encouraged and supported people to engage in a variety of activities within the home such as arts and craft, quizzes and baking.

Improving care quality in response to complaints or concerns
• People and their relatives knew who to talk to if they were unhappy or had a concern of any kind. One person said, "I would speak to [Staff members name]." Another said I would tell [Providers name].
• Relatives knew how to make complaints, felt confident they would be listened to and that the provider would take appropriate action. A relative said, "I don't have any worries but if I did, I would speak with [Assistant manager names or Provider]."
• A formal complaints process was in place and this was displayed for people's, relatives and visitor's information.

End of life care and support
• No one was receiving end of life care or support at the time of the inspection.
• The management team told us that should people's health deteriorate, they would seek advice and guidance from healthcare professionals to ensure people had the right care and support at the end of their lives.
• Managers told us some discussions had taken place with people and their relatives to look at end of life wishes.

Inadequate

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the previous inspection, October 2019, whilst we found some improvements had been made the service needed time to fully embed those changes. We recommended that the provider continued to review the systems in place to monitor the service to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been sustained.

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

- The providers failure to act upon feedback from previous inspections and enforcement action taken by the Care Quality Commission, meant the service was not compliant with the regulations; service users continued to be exposed to the risk of harm and the provider was in breach of a condition of their registration.
- The providers oversight and governance of the service was inadequate in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe, effective, caring and responsive sections of this report. For example, the providers told the inspector that they were shocked to find out that some people did not have a pre-admission assessment or care plan in place or that care reviews had stopped taking place.
- Leaders did not have the skills, knowledge and experience to perform their roles. The culture of the service did not reflect best practice guidance for supporting people with a learning disability and/or autistic people.
- Managers and staff, had no understanding of Right support, right care, right culture guidance published by CQC, or how the underpinning principles could be used to develop the service in a way which supported and enabled people to live an ordinary life, enhanced their expectations, increase their opportunities and value their contributions.
- The provider and managers failure to follow and embed the services own policies and procedures which were designed to support staff, assess and monitor quality within service delivery. For example, in relation to care planning, risk management, mental capacity, positive behavioural support, epilepsy, supervision, and infection prevention and control.
- Systems were not in place to demonstrate accidents and incidents were effectively monitored, reviewed or used as a learning opportunity. This meant that when things had gone wrong, the potential for re-occurrence was high because insufficient action had been taken to review, investigate or learn lessons.
- Regular medicines audits did not identify the concerns we found at this inspection.
- Poor judgements/decision making potentially placed people at risk of harm. For example, the providers failure to act on advice provided by an external health and social care professional and to adhere to their own Personal Protective Equipment Policy and Procedure, placed people, staff and visitors at an increased

risk of harm.
• Records and checks undertaken by managers and staff were not always accurate and as such could not be relied upon. For example, an assistant manager said they had taken home audits relating to PPE and Infection control from June 2021 to complete retrospectively. This meant they were not an accurate or contemporaneous reflection of their observations.'
• Governance systems and processes had not identified that records were not always accurate or fully completed. This meant the provider was unaware that care reviews had stopped taking place, that environmental risks had been identified but action had not been taken or that Information relating to a safeguarding incident could not be found.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People were not involved in a meaningful way in the development of their care and support and information was not provided in a way which met people's individual communication needs.
• Managers who were in day to day control of the service had limited understanding of how to support people in accordance with the Health and Social Care Act 2008 and seemed to be unaware of the culture they were creating within the service. For example, institutionalised practices, in the form of weekly hand washing for all people living at the service had been introduced and described as evidence of good practice.
• The provider had not ensured the staff understood the principles of the MCA. This lack of knowledge and understanding risked compromising people's rights.
• A poor staff culture created a lack of professional challenge that impacted on people's safety. Whilst it was clear that staff cared about people the culture of the home was not one where people were encouraged and supported to be the best version of themselves.

The provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Relatives we spoke with continued to have confidence in the service and told us the service was well managed. Comments included; "There's a very good manager who instils a certain ethos." and "I think it's well managed, I've never had any worries, but I would ring them if I did."

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 registered provider and assistant managers understood their responsibilities in relation to duty of candour. Duty of candour requires that providers are open and transparent with people who use services and other people acting lawfully on their behalf in relation to care and treatment. However, the provider had not notified the Care Quality Commission of an incident which had been reported to, or investigated by, the police in line with their legal responsibilities.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

• The registered provider had failed to notify the Commission of a death of a person who used the service in line with their legal responsibilities.

This was a breach of regulation 16 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

Working in partnership with others

• The service had developed working relationships with other health and social care professionals which meant advice and support could be accessed as required.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The registered provider had not notified the CQC without delay of the death of a service user in line with their legal responsibilities. Regulation 16 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the CQC of significant events in line with their legal responsibilities. Regulation 18 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People's right to privacy was not always respected or understood by staff. Regulation 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014

personal care

Premises and equipment

The provider had failed to ensure the premises were suitably maintained for the purposes for which they are being used.

Regulation 15 (1)(a)(e)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure each person had a care and support plan designed to achieve their needs, wishes and preferences and ensure staff provided person-centred care and support. The provider failed to ensure that people were supported and empowered to have choice and/or control over the way they were cared for. The provider failed to ensure that people's needs were assessed

The enforcement action we took:

On 26th July 2022, the Commission served notice under Section 28(3) of the Health and Social Care Act 2008, to adopt the Commission's proposal to cancel your registration in respect of the regulated activity. Accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way Risks to people's health and safety had not been identified or mitigated. Medicines were not always stored or managed safely The provider had failed to ensure that people, staff and visitors were protected from the risk of and spread of infection.

The enforcement action we took:

On 26th July 2022, the Commission served notice under Section 28(3) of the Health and Social Care Act

2008, to adopt the Commission's proposal to cancel your registration in respect of the regulated activity. Accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People and staff were potentially placed at risk as the systems in place were ineffective, did not drive improvement and did not identify the issues we found at this inspection.

The enforcement action we took:

On 26th July 2022, the Commission served notice under Section 28(3) of the Health and Social Care Act 2008, to adopt the Commission's proposal to cancel your registration in respect of the regulated activity. Accommodation for persons who require nursing or personal care.