Burlington Care Limited

Southlands

Inspection report

15 Hobman Lane
Hutton Cranswick
Humberside
YO25 9PE

Tel: 01377270271
Website: www.burlingtoncare.com

Date of inspection visit:
09 August 2022
16 August 2022
22 August 2022

Date of publication:
01 November 2022

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

About the service
Southlands is a residential care home providing accommodation and personal care for up to 48 older people who may be living with dementia or a physical disability. At the time of the inspection, 38 people were using the service.

People's experience of using this service and what we found
Risks to people's health and safety were not always identified and managed as records were not up to date and staff did not always have access to required information. Fire safety processes were not appropriately followed. Staff were not effectively trained and supported in their roles and the provider had not ensured there were sufficient staff on shift to meet safely people's needs. We have made a recommendation about staff recruitment processes.

People's medicines were not managed safely. Not all areas of the service were clean and personal protective equipment (PPE) was not stored and used appropriately by all staff. People's nutritional and skin care needs were not always met and referrals to healthcare professionals were not made in a timely manner. There was a lack of activities and social stimulation for people.

Systems to ensure people's rights were upheld were ineffective as legal authority to deprive people of their liberty had expired and conditions were not always met. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Governance systems were ineffective at identifying and addressing shortfalls and where shortfalls were identified, prompt action was not taken. There was a lack of meaningful oversight by the provider.

People's relatives told us staff were caring. However, opportunities to engage with people were missed as staff were busy. Staff supported people to maintain their independence and dignity.

There was a poor culture at the service and staff did not always feel supported. The provider had increased support to the service and staff due to the significant shortfalls in the service.

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

Rating at last inspection
The last rating for this service was good (published 19 May 2021).

Why we inspected
We received concerns in relation to the management of medicines, staffing, poor care and management of

the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We inspected and found there was a concern with medicines, staff training and deployment, fire safety, managing risks and meeting people's needs, so we widened the scope of the inspection to become a comprehensive inspection which included all the key questions.

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.

Enforcement and Recommendations
We have identified breaches in relation to medicines, risk management, infection control processes, meeting people's care and nutritional needs, staff numbers and training, maintaining people's rights and maintaining the quality and safety of the service at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 rating, 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Southlands

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 first day of the inspection was completed by one inspector and one medicines inspector. The second day of the inspection was completed by one inspector and a specialist advisor who was a registered nurse. The final day of the inspection was completed by one inspector. During the inspection, an Expert by Experience sought feedback from people's families by telephone. 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
Southlands is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Southlands is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager, but they were not at work during the inspection.

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 safeguarding and contracts teams. 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 all this information to plan our inspection.

During the inspection
We spoke with 14 members of staff including four members of the senior management team, one interim manager, one senior carer, five care staff, one housekeeper and two agency staff. We also spoke with one person who used the service, six relatives and observed staff interactions. We also received feedback from one healthcare professional. 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 looked around the home to review the facilities available for people and the infection prevention and control procedures in place. We also looked at a range of documentation including care files and daily records for six people and medication administration records for 16 people. We looked at three staff recruitment files and reviewed documentation relating to the management and running of the service such as staff rotas, training and audits.

After the inspection
We requested further policies, information about people's weights, cleaning records, updated training information and continued to seek clarification from the provider to validate evidence found . We spoke with the Local Authority to share our findings and made a referral to the fire and rescue service.

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

- Fire safety risks had not been appropriately mitigated. Staff had not completed fire awareness training or regular fire drills to enable them to maintain people's safety in the event of a fire.
- People at risk of skin damage did not always receive appropriate support. For example, one person did not receive regular support with positional changes and continence care which placed them at risk of harm.
- Risks to people's health, safety and wellbeing were not appropriately monitored or managed. Risk assessments were not regularly reviewed and updated using accurate information. This meant risks could not be effectively monitored and action to manage risks had not been taken in a timely manner.

Whilst we found no evidence people had been harmed, people were placed at risk of harm by the failure to risks were assessed and mitigated. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People's medicines were not managed safely. The provider had submitted multiple safeguarding referrals due to shortfalls in the safe administration of medicines. The provider had acted to minimise risks with administering medicines. However, errors continued, and people continued not receiving their medicines as prescribed.
- People's creams and topical medicines were not administered as prescribed. Records did not show creams were regularly applied and staff told us they did not apply creams as prescribed.
- Personalised risk assessments were not in place for people who were prescribed potentially flammable creams. A generic risk assessment was in place but did not provide appropriate risk management strategies or consider individual circumstances which could increase the risk.

Whilst we found no evidence people had been harmed, people were placed at risk of harm by the failure to ensure the safe and proper management of medicines. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Areas of the service were not always clean. Some areas of the service and furniture were dirty. For example, the lift, a bath hoist, two chairs and a pressure cushion were found to be dirty.
- Good infection control processes were not established in the laundry. The provider had failed to ensure relevant guidance was followed.
- PPE was not stored appropriately, and staff did not always wear face masks correctly, which placed people and staff at risk of harm from infections.

Whilst we found no evidence people had been harmed, people were placed at risk of harm by the failure to ensure effective infection control practices were followed. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment; Learning lessons when things go wrong
● The provider had not ensured there were appropriate numbers of trained and skilled staff on shift. The provider had not reviewed staff skills on shift to ensure they were able to meet people's needs safely.
● The provider had analysed falls at the service to try to learn lessons and had identified the layout of the building contributed to the number of falls. However, they had not updated their dependency tool to take this into account, which meant the provider could not be assured there were sufficient numbers of staff deployed.
● Relatives and staff told us there were not enough staff at the service. Staff said, "We're short staffed, we have various agency staff in which makes it harder for regular staff." Relatives told us, "They look as if they are chasing their tails and they could do with more staff" and "Weekends are quiet, I never see many staff at weekends."

The failure to ensure sufficient numbers of skilled and competent staff were deployed placed people and staff at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They provided training in moving and handling and fire drills.

● Recruitment checks were completed to ensure staff were appropriate to work with vulnerable people. However, interview records were not always fully completed and did not show how the provider had determined staff were suitable for the role.

We recommend the provider reviews and updates their recruitment processes to ensure robust staff recruitment records are in place.

Systems and processes to safeguard people from the risk of abuse
● The provider had identified shortfalls in the safe administration of medicines and had submitted a number of safeguarding referrals to the local authority.
● Staff were trained in safeguarding and understood the signs and types of abuse and action to take if there were concerns.

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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider had not ensured staff were trained to meet people's needs. Staff had not received training in skin care or the prevention of pressure damage despite several people being at risk of pressure damage.
- The provider had not ensured staff had required skills for their roles. Not all care staff had up to date moving and handling training and the provider had not assured themselves staff were competent when moving and handling people. This placed people and staff at risk of harm from inappropriate moving and handling techniques.
- Staff had not received appropriate support, supervision and annual appraisals in line with the provider's policy.
- Staff were not supported to develop their knowledge and obtain nationally recognised qualifications for their roles. Staff told us they would complete qualifications but had not been offered the opportunity to.

The failure to provide staff with appropriate support, training and development placed people and staff at risk of harm. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They provided moving and handling training for staff.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People did not always receive appropriate support to meet their nutritional needs. Some people were not offered their breakfast until nearly lunch time and second helpings were not always offered despite people indicating they were hungry.
- People were not always offered a choice of meals. For people who required a specialised diet, only had one option available which meant people did not have choice and control of their diet as they may not want what was prepared.
- Not all staff knew why people were on specialised diets. This meant staff were not always aware of the risks to monitor and manage.
- Staff had not effectively monitored and managed risks for people who were at risk of weight loss. People were not always weighed in line with their care plans and referrals to relevant healthcare professionals had not been made in a timely manner.

● Communication with healthcare professionals was not always effective. A healthcare professional told us, "There have been different, new and fill-in staff and this does affect effective communication and confidence in client care."
● Staff were not always informed if referrals had been made or outcomes after they raised concerns about people's health and wellbeing.

The failure to meet people's nutritional needs placed people at risk of harm. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They submitted referrals to relevant healthcare professionals and reviewed the provision of meals.

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

● Consent to care and treatment was not always sought in line with legislation as DoLS had not always been applied for before current authorisations expired. This meant some people were deprived of their liberty without the lawful authorisations being in place.
● There was a lack of oversight to ensure conditions of DoLS were met. Care plans were not always updated following DoLS being granted and conditions were not always included or met.

The failure to ensure the effective oversight of safeguards for people deprived of their liberty placed people at risk of their rights not being upheld. This was a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff sought people's consent before providing support.
● People's mental capacity had been assessed and where decisions had been made in their best interests, people and their relatives had been involved.
● Records were in place for those with the legal right to make decisions on people's behalf.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● People's needs were assessed and information was used to create care plans and risk assessments. However, they were not always regularly updated and did not always reflect people's needs.
● People's rooms were personalised to their tastes. People had displayed pictures, ornaments and objects of interest to make their room feel like home.

- Pictorial signage was used to help people find toilets, bathrooms and communal areas.

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;
● Although relatives spoke fondly of staff, we found low staffing levels sometimes impacted on the quality of care and interactions. Feedback from relatives included, "They go above and beyond I am delighted with them" and "I think they are, very kind and caring." Staff missed opportunities to engage with people as they were focused on getting jobs done. One person was distressed as they wanted some biscuits. Staff acknowledged them as they passed but did not engage with them to meet their needs.
● Although staff found their roles difficult at times, they were passionate about providing the best care they could. Staff said, "We always try our best, our residents are at the forefront and the reason we are here" and "We all work hard and we all want the best for the residents. We really do care, but sometimes you don't feel like you get the support you need."

Respecting and promoting people's privacy, dignity and independence
● Staff were knowledgeable how to maintain people's privacy and dignity, though they felt there was inconsistency in how people were supported by agency staff. A staff member told us how they maintained people's dignity during personal care tasks but had seen agency staff not providing the same level of care.
● Relatives confirmed where possible staff maintained people's independence. A relative said, "[Staff] wait to see if [Person's name] needs help to eat as some days they like to do it themselves."

Supporting people to express their views and be involved in making decisions about their care
● Staff tried to include people in decisions about their care, but chances to do so were missed. For example, a choice of meals was not always available for people, which limited their ability to have choice and control over their life.
● The provider was reviewing care plans and people's relatives had been invited to contribute to them. Relatives told us, "We reviewed it a week ago" and "We review it every year, the latest one is dealing with end-of-life care."
● Most people's relatives told us they were included in decisions and their views were listened to. One relative said, "I am very much involved, I have a Lasting Power of Attorney and stressed I want to be part of any decisions made."

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 good. At this inspection the rating has changed to 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; 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's care plans were not always up to date and did not always reflect people's needs and the support they required. For example, staff told us one person became distressed during personal care tasks. However, their care plan had not been updated to include this or guide staff how to support the person appropriately.
- People were at risk of social isolation as there was a lack of activities and social stimulation. At the time of the inspection, there were no activity staff employed and no activities took place. One person told us they would like to take part in more activities. However, they spent their time colouring in as there wasn't anything else to do.

The failure to ensure care was personalised and met people's needs placed people at risk of not receiving appropriate support to meet their needs. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported to maintain their relationships with families and friends through visits and phone calls.

End of life care and support

- Staff were not trained in end of life care which meant the provider could not be assured people would receive appropriate care at the end of their lives.
- People and their relatives had been invited to discuss their wishes and preferences regarding care at the end of their life, though care plans contained little personal information, which meant people may not be cared for as they wished.
- Staff liaised with healthcare professionals to ensure people had appropriate medicines in place to support people to have a pain-free dignified death.

Meeting people's communication needs

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.

- Staff understood how people communicated. Their communication needs were recorded in their care

plan. A relative told us, "[Person's name] struggles with their speech so staff have to be understanding and spend time with [Person's name] and can't rush them."

● Some people benefitted from visual tools to help them communicate. However, visual tools were not always available to support communication. Menus did not contain pictures and sample meals were not shown to people to help them understand the choices available.

Improving care quality in response to complaints or concerns

● Processes were in place to support people and their relatives to raise concerns and complaints about their care.

● Complaints were addressed in line with the providers policy and procedure.

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 good. 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.

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

- There was a lack of effective systems in place, or where they were, they were not operated effectively to ensure compliance with the regulations. For example, a health and safety audit had not identified all staff had not participated in regular fire drills.
- The provider's governance schedule was not always followed. For example, monthly mattress, wheelchair and sensor equipment checks had not been completed to ensure equipment was still suitable and safe to use.
- Governance systems in place had not identified shortfalls which we found in medicines, infection control, DoLS, staffing and staff deployment.
- Where shortfalls had been identified, action was not taken in a timely manner to address safety and quality concerns. For example, shortfalls were identified in moving and handling training. However, practical training was not arranged and competency assessments were not completed.
- The provider failed to learn from their own analysis of accident and incidents to improve the safety of the service.

The failure to implement and operate effective systems to maintain the safety and the quality of the service placed people at risk of harm and of receiving a poor-quality service. This was a breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- There was a poor culture at the service which meant people's needs were not always met in a timely way and risks were not always managed which had a negative impact on people's health and wellbeing.
- Shortfalls in the management of the service had a negative impact on local healthcare services. A healthcare professional told us the unsafe management of medicines had added extra strain to the service they provide.

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

- Staff told us there was poor communication and they were not kept informed about what was happening at the service. Staff meetings had been held, though the last one was in July and there had been a lot of changes to the service since then. A staff member said, "Just recently it has been very hard emotionally and

physically. There are things are going on in the background, but we haven't been informed. People come in the office, but we are not introduced, there is no continuity."

● Systems were in place to gain feedback from people and relatives. Meetings were held for people using the service, though the last meeting was overdue. Relatives had completed a questionnaire about the service. A relative told us, "[Relative's meetings] stopped during COVID, now they send out surveys, one was done early this year."

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 provider understood their responsibilities in relation to the duty of candour and ensured relatives were kept informed about significant events. They also notified CQC about incidents that affected people's safety and welfare.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure care was personalised and met people's needs. Regulation 9 (1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to have effective systems in place to assess, prevent, detect and control the spread of infections, assess and mitigate risks to people's health, safety and wellbeing and had failed to ensure the safe and proper management of medicines. Regulation 12 (1)(2)(a)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had hailed to ensure the effective oversight of people's rights and safeguards for people deprived of their liberty. Regulation 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure people's nutritional needs were met.

Regulation 14 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement and operate effective systems to maintain the safety and the quality of the service. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of skilled and competent staff were deployed and had failed to provide staff with appropriate support, training and development. Regulation 18 (1)(2)(a)(b)

The enforcement action we took:

Warning notice