Burlington Nursing Home Limited

Burlington Nursing Home

Inspection report

109-111 Victoria Drive
Bognor Regis
West Sussex
PO21 2DZ

Tel: 01243821446
Website: www.burlingtonnursing.com

Date of inspection visit:
10 December 2018
12 December 2018

Date of publication:
12 October 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Burlington Nursing Home accommodates a maximum of 40 people in one adapted building. At the time of this inspection 30 people were living at the home. Most people who lived at the service were living with dementia. 21 people received a service to support more complex nursing level needs, while nine people received a personal care service to support those with lower residential care needs.

People's experience of using this service:

New staff had not been always been recruited safely and people could not be assured that new staff were of good character. This placed people at risk. We raised this with the registered manager who took action to address this during the inspection process. New staff were taken off the rota and replaced by agency staff while more thorough recruitment checks were completed.

Medicines were given safely to people. However, we found that staff did not always follow the advice and recommendations of an external healthcare professional which meant that one person did not always receive 'As required' medicines for pain relief when this may be needed.

Risks were not always clearly assessed for people. The action staff may need to take to safeguard people from harm or to provide person centred care was not always detailed in records. Nutritional risks were not always assessed accurately which may place people at risk of harm from malnutrition.

Electronic care plan records for people did not contain detailed, personalised information or medication assessments. There was a risk that new staff or agency staff would not know how to meet people's needs safely or in accordance with their personal wishes and preferences. By the end of the inspection process the clinical lead had begun to improve the basic information held in people's electronic records.

Since the previous inspection in July 2018, the provider had taken action to improve aspects of the service provided for people. We issued two warning notices at the previous inspection, the conditions of which had now been met. Lifting equipment was safely maintained and water quality was monitored safely. Despite this, aspects of the governance and leadership of the service were not effective in identifying some significant service shortfalls such as gaps in the recruitment processes for new staff.

An independent consultant had been commissioned by the provider to support them to make positive changes to the service. An electronic care planning system had been purchased and was being implemented at the time of this inspection. However, at the time of this inspection these improvements had not been fully embedded in daily practice and further breaches of Regulations were found. This meant that the provider did not always meet the legal requirements of their registration with the Care Quality Commission [CQC].

Despite some of the ongoing concerns identified, we observed that people were treated kindly by care staff throughout the inspection process. At the time of this inspection, people's relatives that we spoke to were positive about the experiences their relatives had at the service. Health and social care professionals told us that the provider and registered manager had been working positively with them to improve the service since the last inspection. Training and weekly support had been provided by West Sussex County Council to staff and the registered manager to help them to improve the service people received.

Rating at last inspection: Inadequate (25 October 2018).

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Why we inspected: We inspected within six months since the last inspection based on the previous rating of 'Inadequate.'

We reviewed the providers progress against the two warning notices that had been issued by us at the last inspection. These had been issued for 'Safe care and treatment' and 'Good governance.' We found at this inspection that the provider had taken sufficient action to address the concerns raised within the warning notices and they had now met these. However, we found ongoing breaches of Regulations at this inspection. Further information is in detailed findings below.

Enforcement: At this inspection we found breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the end of this report.

Follow up: This service remains in special measures. We will continue to closely monitor this service and inspect again within six months of this inspection date to review any progress made.

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 always safe Details are in our Safe findings below.	**Requires Improvement**
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 responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Burlington Nursing Home

Detailed findings

Background to this inspection

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

Inspection team: The first day of the inspection was carried out by one lead inspector, one pharmacist specialist inspector and one nurse specialist advisor with expertise in the care of people living with dementia. The second day of inspection was carried out by one lead inspector.

Service and service type: Burlington Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care. 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: The inspection took place on the 10 and 12 December 2018. The first day of inspection was unannounced. The second day was announced.

What we did: We reviewed information we had received about the service. This included details about incidents the provider must notify us about and we sought feedback from the local authority and health professionals who worked with the service. We had also received some information of concern from two relatives of people who had lived at home before we completed this inspection. Due to the fact that we visited the service within 12 months of the last inspection to review the previously identified concerns, the provider was not requested to complete a further Provider Information Return (PIR). The provider had completed a PIR in July 2018 before our last inspection. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the actions the provider had taken in relation to the previous breaches of our Regulations and

two warning notices and took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

Before, during and following the inspection we reviewed and spoke with;

• Eight people's care records and risk assessments
• 15 people's medicines administration records [MARs]
• Three staff recruitment, training and supervision records
• Records of accidents, incidents, complaints and compliments
• Audits, quality assurance reports, provider action plan and previous warning notices
• Observed an afternoon activity experience for people in the communal lounge area
• Spoke to; the registered manager, registered provider, clinical lead, qualified nurse on duty at the home, office administrator, two care assistants and an independent management consultant
• We spoke with two visiting relatives and one friend of a person who lived at the home
• We also spoke with a community admission avoidance dementia specialist matron, a community admission avoidance matron, two West Sussex County Council contract monitoring officers, a lead professional from the West Sussex County Council Care and support team, a specialist community and diabetes dietitian and a visiting chiropodist.

Requires Improvement

Is the service safe?

Our findings

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.

Systems and processes; assessing risk, safety monitoring and management; using medicines safely; preventing and controlling infection and staffing levels:

• At our last inspection in July 2018, this key question was rated as 'Inadequate.' This was because lifting equipment was not safely maintained which placed people at risk of significant harm. Environmental risks such as fire risk assessments and Legionella water quality monitoring were not always assessed or responded to safely and medicines were not always safely managed. We also found that lessons were not learned following previous inspection report outcomes.
• This was a breach of Regulation and we served a Warning Notice to the provider and registered manager to ensure that the shortfalls were addressed promptly.

• Since the last inspection the provider had employed an independent management consultant to support the service to address and improve the areas of concern that we had identified.
• At this inspection we found that the provider had addressed the previous concerns within the Warning Notice and had now met the requirements of the notice. Lifting equipment was safely maintained. Fire safety risk assessments and legionella checks were completed appropriately. Medicines management practice had improved. However, we found further areas of concern during the inspection. Systems and processes did not always protect people from the risks of avoidable harm.

• Whilst staff were able to explain the basic principles of reporting any concerns of abuse that may arise appropriately, aspects of day to day management practices at the service remained unsafe, examples of this are set out below.

• People were not protected by safe staffing and recruitment practices.
• We reviewed records for new staff that had been recruited since our last inspection in July 2018. We reviewed two of the three new staff members files and found that appropriate recruitment checks had not been completed. For one staff member, no Disclosure and Barring Service [DBS], 'DBS Adult First' checks or any references from previous employment or character references had been received. the DBS Adult First allows an individual to be checked against the DBS Adults' Barred List. Dependent on the result of the check, this service allows the individual to start work under supervision while waiting for their full DBS check results.
• We addressed these concerns immediately with the registered manager who suspended the new carer from duties until full recruitment checks had been completed.
• The staff member had been working unsupervised without any safety checks that are required in law to indicate if they were of good character. The registered manager confirmed this had been the case. This placed people at risk of avoidable harm.
• An induction or relevant training had not been completed by a new staff member. They had only worked in

a community care setting for three months before they started work at Burlington Nursing Home. They had no other previous experience of working in care.
• The provider did not therefore always provide staff who were suitable skilled or trained to work with older, vulnerable people living with dementia. This placed people at risk of harm.
• The provider did not have robust, safe recruitment practices.

This was a breach of Regulation 19 [Fit and proper persons employed] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Infection control practices were not always safe. Whilst most staff received infection control training, new staff were not always adequately trained in infection control and did not always demonstrate safe practice to reduce the risks of infection to people.
• There had been concerns about a new staff members conduct and a lack of their understanding of adequate or appropriate infection control measures. Supervision notes documented by the clinical lead evidenced that the staff member had been seen wearing gloves outside of a person's room following personal care support. This is not in line with best practice guidance. Gloves should be removed and hands washed before leaving a person's room. They had not used personal protective equipment [PPE] such as gloves appropriately. The new staff member had not received training to understand correct infection control techniques. This had been addressed with them by the clinical lead.
• Other staff on duty were seen to use PPE correctly during the inspection.

• There was an unpleasant odour throughout the ground floor of the home during both days of this inspection. This was discussed with the provider. They informed us they were replacing carpets and flooring in this area of the premises to reduce this. It was evident that this work had started at the time of this inspection.

• Despite improvements with the management of medicines since our last inspection, some practices were not safely managed.
• For one person their medicines prescribed on an 'as required' basis had not been given as community dementia specialist admission avoidance matron had requested. This had been requested for the management of pain. The person had regularly displayed some behaviours which may have been caused by pain in the matron's professional opinion.
• This failing had been raised immediately with the registered manager and clinical lead during the inspection by the community matron.
• Following the inspection the community matron confirmed that the medicines had since being given for the management of suspected pain. They also stated they would more closely monitor the service and use of 'as required' medicines for people.
• The community matron also found that pain monitoring charts which should contain signs and symptoms to look out for and when to offer the medicine had not always been completed correctly to show when people may need pain relief 'as required.' Additional training had been offered by the community matron to ensure that staff completed pain monitoring charts correctly. This had not been completed at the time of this inspection.
• A member of care staff explained how they applied creams to people as part of their personal care. We asked a care worker and a nurse about recording the administration of creams for four people. These records were inconsistent with most lacking a record that creams had been applied. We could therefore not be assured that people received creams as prescribed.

• Risks to people were not always assessed with sufficient detail or reassessed quickly enough when things may have changed.

• For example, the provider had implemented a new electronic care planning system which had replaced all paper based care plan and risk assessment records. Within the new system there were no medication assessments for people.
• For people who were prescribed blood thinning medications [such as Warfarin] there were no assessment plans to highlight risks for people when taking these medicines and considerations that care staff and kitchen staff should be aware of. This may include certain foods that should be avoided when taking such medicines.
• The medication policy used at the service was not up to date and did not reflect current legislation.

• People who may be at risk of malnutrition may not receive the care they required. A specialist community and diabetes dietitian completed a review of the homes 'NRICH' accreditation in November 2018 and found that the home had failed to retain this accreditation. This nutrition resource in care homes programme was run by dietitians to support care homes to better manage risks to people at risk of malnutrition. A detailed training programme was provided to the home as part of this programme.
• The failure to maintain this accreditation was due to the fact that staff had not completed the MUST [Malnutrition Universal Screening Tool] correctly for people or consistently updated records for people regarding their nutritional risks. Only 57% had been completed correctly of those reviewed.
• For two people who were at risk of malnutrition, no MUST risk assessment or nutrition care plans could be located. For three further people, their care plans had not been updated following a review of their MUST score. A community dietician told us, "If a person's risk of malnutrition continues to increase, the likelihood of them experiencing negative consequences also increases. These include, an increased risk of infection, hospital admissions and falls."
• The provider did not consistently operate systems that safely monitored or responded to risks for people regarding infection control, management of medicines or nutrition.

The above concerns are an ongoing repeated breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite the ongoing breach of Regulation, people and the relatives said they were happy and felt the service people received was safe.
• A staff member told us, "I don't think there are risks at the moment. As far as patients [people] are concerned, they are safe." One person's friend visiting the service said, 'As far as we are concerned he is happy and he feels safe and I feel he is safe."
• Systems and processes at the home had provided some improvements to the monitoring of daily care received for people. However, some improvements were required to embed the new system into practice.
• The new electronic care plan system ensured that care staff were able to send an 'alert' to a nurse on duty to feed back any safety concerns or actions that may be required for people. This may include calling a GP or asking a nurse to review a person's skin if a staff member suspects skin breakdown, for instance.
• The nurses could not cancel the alerts. The registered manager and clinical lead were able to cancel the alerts. The registered manager said, "It's our first job of the day. To address and cancel the alerts once we are happy they have been actioned [by the nurses], we cancel them." However, we found that this system was not yet fully implemented or embedded in practice. Some 'alerts' had not been responded to for a period of 20 hours. This meant that this system did not yet provide robust assurances about the care and treatment people received. This is an area that required improvement.
• Falls risk assessments were completed in detail for people but plans to support people who may display behaviours that may challenge were not always detailed or personalised.
• A community admission avoidance matron stated that the home had started to work with them and to take advice from them regarding pressure area care for people, which they stated was "positive."

Learning lessons when things go wrong:

• The provider had taken steps to improve the service and to learn lessons when things went wrong. Improvements had been made and some lessons had been learned following our previous inspection outcomes in July 2018. However, further improvements were required to systems and monitoring arrangements for the ongoing quality and safety of the home to ensure that people were robustly and consistently protected from the risk of harm or avoidable abuse.

Requires Improvement

Is the service effective?

Our findings

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At our last inspection this key question was rated as 'Requires improvement.' This was because staff training and supervision had not always been provided effectively. There were two breaches of Regulations. At this inspection we found that some improvements had been made to staff training and trained nurses had received medicines training. However, we found ongoing breaches of Regulations.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law and supporting people to eat and drink enough with choice in a balanced diet:

• People's needs were assessed when they moved into the home. However, some aspects of daily care provided was not reassessed. This included people's preferences regarding meal choices.
• People were not always involved in decisions about what they ate and drank and for some meals personal choices were limited. The review of the NRICH [nutrition resources in care homes] programme completed by a specialist community and diabetes dietitian in November 2018, found that, "Resident's breakfast choice is made when they first come to the nursing home." They recommended that the home should, "Try to offer a variety of breakfast options to all residents daily to reduce repetitiveness." They also recommended a further area for improvement; "Consider increasing the number of main meal and pudding options available each day (only one option available per day at the moment)." This had not been addressed during this inspection. We will review this at our next inspection.
This is an area that requires improvement.

• People's records did not always contain sufficient information to support people's preferences to ensure they received care and treatment that ensured their emotional needs were responded to in a person centred way. This meant their 'protected characteristics' such as age, gender and disability, including those who lived with dementia, were not always respected regarding care and support decisions.
• Whilst people's needs were assessed, the new electronic care planning system did not always contain person centred information about people's needs or their desired outcomes. A nurse specialist advisor with expertise in the care of people who lived with dementia said, "I'm not finding how they [staff] are supporting people with dementia emotionally. From reading the care plan I don't know people. No life histories."
• However, during the inspection we observed care staff knew people well and were able to respond to people's needs using appropriate communication that was positively responded to by people.
• Four people received medicines for long term conditions which included 'COPD' [chronic obstructive pulmonary disease] that required regular monitoring. Care plans were not available to support staff to look after these people. This meant staff members who were new to the service and did not know people well, would not have sufficient information to look after them effectively.

• Since the last inspection in July 2018, food 'satisfaction surveys' and small 'focus group' with seven people had taken place. This showed that the provider had tried to improve the eating and drinking experience for

people. However, the findings from the community dietitian demonstrated that this continued to be an area that required improvement.
• Technology such as pressure mats were used to enhance people's independence. This enabled some people to walk more independently in some areas of the home, with staff being alerted if assistance may be required.

Staff providing consistent, effective, timely care within and across organisations and supporting people to live healthier lives, access healthcare services and support and staff skills, knowledge and experience:

• People did not always have access to healthcare in a timely and coordinated way. Assurances were not always consistently evident that people would receive a timely response to their healthcare needs.
• During the inspection process, the nurse specialist advisor noted that an area of the building was cold. This was raised with the provider who was asked to turn up the heating in this area of the home.
• A person was being cared for in bed within this area of the home. The nurse advisor was concerned about them because they appeared to have some difficulty breathing.
• The home's clinical lead was asked by the specialist nurse advisor to call the doctor for the person as this had not been done. The GP visited and prescribed antibiotics to the person for a diagnosed chest infection.
• The new electronic care planning system aimed to enable care staff to alert the nurse on duty if they were concerned about people's wellbeing. However, an alert had not been raised by staff to request healthcare support for this person's breathing difficulties.
• We did not receive assurances that this system was fully effective at the time of this inspection. No healthcare assistance had been sought for the person before the inspection team identified and requested this intervention.
• Nursing staff did not follow recommended monitoring for the person who had a history of developing 'sepsis'. This is a serious condition caused by infection, potentially leading to organ failure, shock, and death.
• Since our last inspection in July 2018, A community admission avoidance and community dementia specialist matron, had provided training support to the home. This included training for 'NEWS' [national early warning score] to support nursing staff to review people's observations for the risks associated with sepsis. The NEWS had not been used to monitor the person. We asked the nursing staff to use the NEWS for the person which they said they would do.
• On the second day of this inspection we were told that this person's condition had improved.

• People who received care at Burlington nursing home lived with dementia. At the time of this inspection, the registered manager told us that staff had, "not as yet completed dementia training." They also said that other training methods for staff, such as e-learning were being looked into, but were, "aspirational at this time."
• We observed that the management team did not always fully explore people's abilities in relation to dementia care in line with best practice recommendations and national guidance. There was a lack of engagement and mental stimulation for people who remained in their bedrooms if they lived on the first floor of the premises. Care staff did not actively address this or demonstrate understanding that there was more they could do to support these people who were living with dementia. This is an area that required improvement.
• Staff confirmed that they needed further training. A member of care staff told us, "I think more training is needed. I think more training overall and refresher training. Things always change."
• The registered manager told us that, "Staff supervision and appraisals are in development and are being prioritised by need at the moment." The registered manager said they wanted to implement short, medium and long term goals for staff but that this had not yet been completed at the time of this inspection.
• New staff members had not received sufficient mentoring or supervision in their roles. We discussed this

with the registered manager.
• An experienced member of staff told us, "They [new staff] need more one to one with nurses or senior carers."
• The provider had failed to provide effective training and supervision to ensure consistently effective care for people.

This is an ongoing breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• For other concerns about people that care staff had entered, the new electronic system had been more effective. The 'handover' information and 'alert' system provided actions for nursing staff which were addressed by them.
• Since our last inspection in July 2018, medication training had been completed by nursing staff.
• The registered manager said, "Staff meetings are happening more regularly now, as well as in the evenings. We need to have a trained nurse meeting soon. Staff do just wander in [to office] if they have anything to talk about."
• We spoke with a community chiropodist who had visited the home for "20 years." They told us that, "They [staff] always contact me if people need foot care. Especially when they have come in from the community and their foot health isn't as good as it could be." They also said, "I leave a report and flag anything they need to keep an eye on and they always do. I look forward to coming here. It's a nursing home but hasn't lost that homely feel like some other homes. It' has a cosy feel. I've never had really concerns about people's foot care." This showed that for some aspects of healthcare people did receive a timely and consistent approach from staff and a visiting healthcare professional to the home.

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 Act requires 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

• At our last inspection we found that staff had staff did not fully understand the Mental Capacity Act. People were not always supported by staff who understood how to provide care in their best interests. This was a breach of Regulation. At this inspection we found that mental capacity assessments were now completed in more detail for people and that staff had received training to support their understanding of MCA and DoLS.
• The registered manager had a 'DoLS tracker' which enabled them to monitor those people who had DoLS application that had been authorised by social services and any conditions that people may have.
• 'Conditions' of DoLS were understood and met by the provider. This ensured that people were supported to live in least restrictive ways, where possible.

Adapting service, design, decoration to meet people's needs:

• Over half of people who lived at the home required staff support to move and many remained in their bedrooms during the day and night. People's bedrooms were personalised with their individual belongings.

• People were able to receive visitors in their bedrooms when desired.
• There was a recently decorated lounge on the ground floor that provided a pleasant space for people to meet with visitors or to watch the television quietly away from the main communal lounge area. We observed one person enjoyed using this separate lounge.
• The provider told us how people had been involved in decisions about the carpets and decoration of the lounge area.
• Signs with pictures were displayed on communal area doors to show people who may be living with dementia where facilities such as the toilets or lounge areas were. This may support people to orientate around the home more effectively.

Requires Improvement

Is the service caring?

Our findings

People were not always supported and treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence:

• We last inspected the service in July 2018. This key question was rated as 'Requires improvement.' The provider had not always ensured people were treated with dignity and respect and confidential information was not held securely. This was a breach of Regulation.
• At this inspection some improvements had been made to systems and process and records were held securely in line with data protection legislation. The new electronic care planning system ensured that records about people were held securely with password protection used by staff to access information about them.
• However, the electronic records did not always contain enough personalised detail for staff to know how to meet people's complex communication needs well. This is area that requires more time to embed into practice. We will review this at our next inspection.
• Despite this, we found that the quality of care people received had improved since the last inspection and no breaches of Regulations were found under the 'Caring' key question.
• People were seen to be treated with kindness by care staff. We observed some positive interactions between people and staff and a nurse that we spoke with knew people's individual needs well.
• People and their relatives that we spoke with during this inspection told us the service was caring and that they were happy with the care provided.
• People were supported to receive visitors at the service. One person we spoke with confirmed that they were able to receive visitors without restrictions. Their relative also told us they were able to visit when they wished to.
• People's relatives and friends that we spoke with felt their loved ones were treated well and with compassion. One person's friend said, "The care I have observed, there is a real effort to preserve dignity and to be compassionate."

Ensuring people are well treated and supported:

• Care staff took the time to make people feel they mattered. One care staff member was heard to positively compliment a person about their appearance and the clothes they were wearing in a valuing manner.
• Care staff were observed to be aware of the communication needs of people who may have a disability such as dementia or visual or hearing impairment. This ensured people were treated equally and fairly.
• People that we spoke to said they were happy. One person told us, "I'm a very happy person here." Their visiting friend spoke with us and said, "He's happy and content he gets what he wants. As far as we are concerned he is happy."

Supporting people to express their views and be involved in making decisions about their care:

• People were supported to express their views and were involved in decisions about their care when they

were able. People's relatives and friends were involved in decisions about people's care when this was appropriate.
• One person continued to receive regular support from an external advocate as part of their DoLS [Deprivation of Liberty Safeguards] conditions. Staff at the service continued to support the person to access their advocate. An advocate is a person who acts on behalf of another person from outside of the service.

Good

Is the service responsive?

Our findings

People's needs were met through good organisation and delivery.

At our last inspection we rated this service as 'Requires Improvement.' This was because people's assessments and care plans varied in accuracy and detail. We also found that the Accessible Information Standard (AIS) had not been imbedded in documentation for people. At this inspection we found that the providers understanding of AIS had improved. We also found that systems to be able to raise complaints had improved for people and their representatives. Systems and monitoring of end of life care for people had also improved.

Personalised care:

• The provider involved representatives in the care of those who lived at the home. People living with dementia were not always able to be directly involved with decisions about their care and required representatives to provide this support.
• A person's representative who held appropriate legal decision making powers to act on the person's behalf, told us they were involved with the planning and review of the care of their friend who lived at the home.
• They said, "I have been involved with care planning. Fairly recently his care needs have been updated. His needs have been changing and I have discussing this with [registered manager]."
• The clinical lead told us that people's representatives are informed about care plan reviews. Some choose not to attend.
• People's communication needs were identified, including those related to protected equality characteristics such as dementia or sensory loss. Staff identified, flagged, recorded, shared and met the information and communication needs of people with a disability or sensory loss, as required by the Accessible Information Standard.
• The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for adult social care services to comply with AIS.

• At our last inspection in July 2018, we found that technology was used appropriately to respond to people's needs and risks such as the risk of falling. At this inspection, technology, such as 'falls' sensor mats continued to be used to alert staff when people may have fallen in their rooms. Falls were monitored and recorded and referrals were made when required to falls prevention services outside of the home. People's needs continued to be responded to appropriately when they were at risk of falling.
• The provider had used technology in the service to improve care planning since our last inspection in July 2018. Staff were able to access information about people within the new system which provided information which was discussed in 'handovers' at each shift change. Staff confirmed this. However, the new system was still in development and would require more time to become fully embedded in practice. We will review this at our next inspection.
• One person continued to be supported to access the community to attend art classes on a weekly basis.

• We observed a staff member with a 'lead' role for activities engaged people in activities within the main communal lounge of the home. During the inspection process an external entertainer also visited the home to provide 'singing' and 'games.' 11 people were engaged with the musical activities and appeared to enjoy the session.
• An activities 'wall' had been created by the 'lead' staff member in the main lounge which displayed the activities planned for the week ahead. Additional information about any visiting entertainers to the home was also displayed.

Improving care quality in response to complaints or concerns:

• People's concerns and complaints were listened to. Since our last inspection the provider had improved their response to people and their representatives when concerns were raised.
• A person's relative had communicated their dissatisfaction with the service provided within a quality assurance survey completed in October 2018. This had been positively responded to by the provider who had arranged to meet with the relative to openly discuss the concerns they had raised. Minutes were maintained of the meeting which indicated that following discussions with the provider the relative now felt, "Entirely happy about everything" and that they felt "involved" with the person's care.
• An 'easy read' guide to complaints was available in the communal foyer to the home on a notice board. This ensured that the complaints process was more accessible to people and their representatives.

End of life care and support:

• People received care at the end of their lives that was delivered in line with national best practice guidance. The registered manager told us that they had "revalidated" the 'six steps' end of life care pathway accreditation but had not received their certificate at the time of this inspection.
• The registered manager completed the 'north west end of life care model' documentation as recommended as part of the 'six steps' approach, to record the level of intervention and support people needed at the end of their lives.
• The nurse specialist advisor said that nursing staff had a, "Good working knowledge of end of life care" and said that, "The GP comes in when needed [for end of life care]."
• Clear systems ensured that people who did not wish to be resuscitated when this had been formally agreed with them, or in their best interests, by a medical professional and appropriate others, were known to staff. This meant that people were able to die with dignity. This is known as a 'DNACPR' which stands for Do Not Attempt Cardio Pulmonary Resuscitation. Care staff knew which people had DNACPR's so that people's wishes were known and respected.
• DNACPR's were clearly highlighted within the new electronic care planning system which was accessible for care staff via their hand held devices that were linked to this system.

Inadequate

Is the service well-led?

Our findings

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

• At our last inspection in July 2018, this key question was rated as 'Inadequate.' This was because the provider had failed to provide systems that ensured a safe service for people. There had been a history of the service being rated as 'Requires improvement' for two consecutive inspections before we rated the service as 'Inadequate' in July 2018. This showed that the provider was not able to ensure that standards were improved to at least a 'Good' standard of care for people.

• At the last inspection we issued a warning notice for the ongoing breach of Regulation for the lack of good governance across the service. Systems were not well-led or well managed and there were service failings and risks to people as a result of this.
• The registered manager sent us an action plan after the last inspection to tell us how they would make improvements to the service.

• At this inspection they had been working through the action plan which was ongoing and not yet completed. We reviewed progress against the action plan during this inspection and found there had been some improvements with the overall leadership of the service. The specific concerns noted within the previous warning notice had therefore been met. Despite this, we identified further and ongoing significant concerns regarding the governance of the service that meant a breach of this Regulation continued.
• A number of areas that were being worked towards, which included the new electronic care planning system, were still ongoing and not yet embedded in practice. Systems and processes remained inadequate and did not ensure that staff were recruited safely. People were not always referred to healthcare professionals when they needed this intervention. For one person the electronic care planning systems had not adequately 'flagged' to nursing staff that they were unwell and breathless.
• Monitoring of nursing staff and care staff competencies in practice also lacked oversight and had not ben adequately monitored. Nursing staff had received training to enable them to effectively and safely monitor deterioration in people's wellbeing. This training had not been followed in practice when people became unwell. This failure had not been addressed by the registered manager. There was a lack of robust and consistent performance management for the management team and trained nursing staff when they did not always follow best practice.

• There had been an extensive level of support provided to the registered manager from a range of health and social care professionals from outside of the service since the last inspection. Despite this extensive support provided, we found some ongoing concerns and breaches of Regulations at this inspection.
• We did not receive robust assurances at this inspection that the service would be able to consistently

sustain improvements made with the history of the service failing to manage the service well. Performance management improvement action had not been taken by the provider to address the historic and ongoing management service failings with the registered manager at the time of this inspection.
• Recruitment practices were not safe and placed people at risk of unsafe care being provided.
• Training was not yet complete for all staff and some of the learning that had been provided by community admission avoidance matron was not yet fully understood or embedded in practice. This meant that people may have been placed at risk of not always being referred to a GP when this was required.
• New staff did not always receive adequate mentoring, support or supervision in their new roles which placed people at risk of unsafe infection control practice.
• Policies and procedures were not in line with current best practice or legislation and required review and update to ensure care was provided for people that met best practice and legal requirements.
• The provider had failed to provide adequate assurances and the governance arrangements and systems at the home did not consistently identify, monitor or mitigated risks to people.

This was the fourth consecutive breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite the ongoing breach of Regulation, and 'Inadequate' rating of this key question, the provider has worked to aim to address this area of service delivery.
• The owner of the service had become the 'nominated individual' and now shared more of the day to day management responsibilities of the service with the registered manager. They also completed a monthly provider visit to provide additional monitoring to the quality and safety of the service.
• Intensive and ongoing support was provided from a management consultant who had been employed by the provider following our last inspection.
• The deputy manager had left their post and a new 'clinical lead' had been appointed and took a lead role with setting up the new care planning system.
• Since our last inspection, West Sussex County Council's care and business support team had provided regular training, mentoring and visited the registered manager regularly throughout each month. Support and training was also provided from community dietitians and community admission avoidance and dementia specialist matrons.

Engaging and involving people using the service, the public and staff and continuous learning and improving care and working in partnership with others:

• Since our last inspection in July 2018, a 'relatives meeting' had happened and a quality assurance survey had been completed by the relatives of people who used the service in October 2018. A total of ten relatives and friends responded. The results were analysed independently by a management consultant. The feedback was mostly positive for each question asked.
• One question within the survey asked if, "Service users and their visitors were consulted regarding changes in the management of the care treatment and support services." Seven respondents agreed, while two were unsure. One relative strongly disagreed.
• The provider met with the complainant who had disagreed to discuss their concerns. This had resolved the dissatisfaction for the relative. This demonstrated learning following the previous inspection outcomes and a willingness to adopt a more continuous improvement approach. The effective management of the for the person's representatives ensured more positive outcomes were achieved.
• The registered manager told us that, "Staff meetings are happening more regularly [since last inspection], as well as in the evenings. We need to have a trained nurse meeting soon."
• Staff meeting minutes showed that the management consultant had held a staff meeting following our last inspection to update staff about our inspection outcomes. A management team meeting had also been

held.
• Following our last inspection the provider had engaged with health and social care professionals to work to improve the quality and safety of the service people received at Burlington Nursing Home.
• The appointment of an independent management consultant had also supported some service improvements and encouraged more of a culture of learning and development for the registered manager.
• Systems and processes were being developed and implemented, such as the new electronic care planning system, but required review to ensure that gaps such as those related to safe recruitment practices could be identified and addressed by the provider and registered manager.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had repeated this breach of Regulation and people could not be assured that they would receive a consistently safe service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that new staff were recruited safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff always received the relevant training, mentoring and support in their roles

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 not ensured that systems and processes consistently identified areas of service provision that required improvement. Therefore, governance systems were not effective.

The enforcement action we took:

Warning notice