Burlington Nursing Home Limited

# Burlington Nursing Home

## Inspection report

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05 October 2016

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

The inspection took place on 04 and 05 October 2016 and was an unannounced inspection.

Burlington Nursing Home is registered to provide accommodation and care for up to 40 older people who live with dementia. It is situated in a residential area of Bognor Regis, West Sussex. At the time of this inspection, there were 34 people living at the service. The home is purpose built and accommodation is provided over two floors in single occupancy rooms. A passenger lift provides access between the floors. There is a separate seating area and communal open plan lounge with dining area.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were at risk of harm because risks had not always been minimised effectively through appropriate support and regular monitoring. We identified staff had used improper physical interventions for two persons, one of which had recently moved from Burlington Nursing Home. As a result of our inspection, the registered manager, identified they were unable to meet the needs of two people, which resulted in those people being served notice to leave Burlington Nursing Home. Following our inspection, the registered manager was working with the local authority to find a new home that could meet the person's needs.

Staff knew what actions to take should they suspect abuse and received appropriate training in keeping people safe. However, staff and the registered manager lacked insight into what might constitute abuse and neglect by omission of care. Resulting in the registered manager failing to notify the local authority safeguarding team and the Commission of incidents that could constitute possible neglect and other forms abuse. In response to our findings, the registered manager reported all the safeguarding concerns to the local authority safeguarding team, identified at the time of inspection.

Whilst staff were safely recruited, there were not enough staff to meet people's needs. The registered manager agreed with our findings at the time of inspection and following our inspection, had reassessed the needs of people's needs, resulting in the staffing levels being increased by an additional two hours per person, per week for people who received care in bed. . The registered manager told us the additional increase would mean people who spent most of their time in bed would be better supported emotionally and physically. This also meant the service was enabled to be more flexible to meet people's needs.

Staff had completed training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Applications had been made to the local authority for DoLS and some assessments had been carried out of people's mental capacity.  However, we found staff lacked understanding about the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, and obtaining consent and carrying out care and support in

people's best interests. There were restrictions and interventions being used, imposed on people that did not consider their ability to make individual decisions for themselves, as required under the MCA Code of Practice. At the time of our inspection, the registered manager agreed with our findings and had started the process of reassessing people's needs.

Some staff practices showed a lack of respect for people and did not promote their privacy and dignity. We had to intervene on several occasions to ensure people received safe and appropriate care.

For people who were less mobile or who remained in bed, there were few opportunities to engage in activities and people were seen sitting in the lounge or their bedroom with no meaningful activity or positive interaction taking place. People who remained in their bedrooms lacked social stimulation and few opportunities to engage in activities were recorded. We have made a recommendation about improving activities and social stimulation for people who are unable to access the main activities in the home.

We found general concerns in documentation such as care planning and recording, advice from health professionals not transferred to care plans, risk assessments identified issues but lacked some control measures and care plans were not always updated following incidents. There was a lack of follow-through in recording of some issues so it was difficult to see if the care had been provided and the issue addressed. There were gaps in some people's monitoring charts and wound care records.

The registered manager and provider used a series of checks and audits to monitor and improve the quality and safety of the service. There was evidence that this system of quality assurance had delivered improvements but it had failed to identify the issues we found during this inspection.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely. Nurses had completed safe management of medicines training and had their competency assessed annually. The nurses were able to tell us about people's different medicines and why they were prescribed, together with any potential side effects.

Staff enjoyed working at the service and felt well supported in their roles. Staff completed an induction course based on nationally recognised standards and spent time working with experienced staff before they were allowed to support people unsupervised. This ensured they had the appropriate knowledge and skills to support people effectively. Records showed that the training, which the provider had assessed as mandatory was up to date. Staff told us that they felt supported and were in regular receipt of support and supervision.

People were provided with a variety of meals and the menu catered for any specialist dietary needs or preferences. Mealtimes were often viewed as a social occasion, but equally any choice to dine alone was fully respected. People were supported to maintain a healthy balanced diet through the provision of nutritious food and drink by staff who understood their dietary preferences. We observed communal mealtimes where people ate together.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we have told the provider to take at the back of the full version of the report.

## 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 always safe.

Although staff had received safeguarding training and procedures were in place to guide them, some people had been exposed to potential abuse and experienced harm and possible injuries due to improper and unsanctioned physical interventions. Safeguarding concerns were not always identified or reported by staff.

The registered manager had failed to report incidences of possible neglect and abuse to the local authority safeguarding team.

People were at risk of harm because guidance on how to minimise risks was not sufficient and monitoring of risks was not always effective.

People and their relatives told us there were not always enough staff to meet people's needs and we confirmed this from our observations.

Staff had undergone thorough and relevant pre-employment checks to ensure their suitability to support people.

Medicines were managed safely and there were good processes in place to ensure people received the right medicines at the right time.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People's rights may not have been protected because the registered manager was unable to demonstrate that they had always acted in accordance with the Mental Capacity Act 2005 (MCA). Staff did not always understand the requirements of the Mental Capacity Act 2005 code of practice and Deprivation of Liberty Safeguards.

There was not always training available specific to the varied

needs of people staff supported, however staff were knowledgeable about people's care needs.

Regular supervision and team meetings took place for staff.

People were provided with a choice of quality meals, which met their personal preferences and supported them to maintain a balanced diet and adequate hydration.

People had access to healthcare professionals to maintain good health.

## Is the service caring?

**Requires Improvement**

The service was not always caring.

We observed examples of positive interactions and compassionate care provided by staff. However, this was not consistent and we identified concerns in staff approaches and the delivery of some aspects of care, which affected people's dignity, comfort and wellbeing.

We observed people's privacy and dignity was respected.

People were supported to express their views and to be involved in aspects of their care where possible.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People had assessments and care plans of their needs, but these lacked important information about how care was to be delivered in a person-centred way. People's care plans did not always include detail for staff on how to engage effectively with people living with dementia.

Accurate records of people's care were not always maintained. Records of activity for people did not always demonstrate that people received regular social support or stimulation. Arrangements to provide stimulation and social interaction required some improvement.

People who were able to access communal areas received prompt support but people in their rooms were not always responded to promptly if they were unable to use a call bell.

People were able to share their experiences and any concerns raised were quickly addressed.

Complaints were managed in line with the provider's policy.

## Is the service well-led?

**Requires Improvement**

The service was not well led.

The registered manager had failed to notify the Commission of incidents in accordance with the law.

There were mixed views about the management of the service.

There was a failure to analyse information gathered during the quality monitoring process, which meant lessons were not learned and practice had not changed in order to improve the service.

People and their relatives were asked for their views and feedback through a range of surveys and questionnaires.

# Burlington Nursing Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 04 and 05 October 2016 and was unannounced.

One inspector and a nurse specialist advisor undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications received from the registered manager before the inspection. A notification is information about important events, which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern. We were also contacted by two community psychiatric nurses (CPN) from the community dementia team who raised concerns about the safety of people living with dementia at Burlington Nursing Home. They consented to share their views in this report.

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

We looked at care records for six people, medication administration records (MAR), monitoring records for food, fluid and people's weights, five staff files, staff training and supervision records, staff rotas, quality feedback surveys, accident and incident records, staff handover records, activity records, complaints, audits, and minutes of meetings.

During our inspection, we spoke with five people using the service, four relatives, four care staff, the activity coordinator, the chef, the clinical lead who was a registered nurse, the registered manager and the provider. During the inspection, we also had the opportunity to speak to visiting professionals. These included a GP, a

paramedic practitioner and a social worker.

Following the inspection, we contacted a nurse who visits regularly and a social worker to ask for their views and experiences. They consented to share their views in this report.

The service was last inspected on 28 July 2014 and there were no concerns.

Inadequate

# Is the service safe?

## Our findings

Risks to people's wellbeing and safety had not always been effectively mitigated. We looked at how risks were managed. We found individual risks had been assessed and recorded in people's care plans. Examples of risk assessments relating to personal care included moving and handling, nutrition and hydration, falls and continence information. However, we found gaps within care records with poor or missing information to safely manage risks.

For example, one person had a high risk of social isolation and self-harm. The care plan stated the person was at risk of throwing themselves onto the floor and head butting the floor or wall. The person did not have a care plan to help guide staff in identifying ways to monitor their self-harm or how to provide support to them. The person had received injuries from this behaviour, which included head wounds. The records were not always clear in how this was being monitored, and as a result, we were unable to identify if the wound were healing.

We found that risks to people's safety as a result of people's behaviours were not always assessed and planned for. For example, one person who used the service frequently displayed episodes of verbal and physical aggression towards other people who used the service and staff. The risks associated with these behaviours had not been planned and there was lack of guidance for staff to follow. For the same person, the care plan indicated that staff should document the behaviours on an Antecedent-Behaviour-Consequence (ABC) Chart. This direct observation tool can be used to collect information about the events that are occurring for a person within an environment. "A" refers to the antecedent, or the event that precedes behaviour. The "B" refers to observed behaviour, and "C" refers to the consequence. We found one entry on the record and no further evidence that these records were being completed. The impact of this means, that the person's behaviours are not being regularly reviewed and analysed to ensure the support from staff is the most appropriate. Staff told us and we saw that they did not know how to manage these behaviours.

Records looked at showed for another person; they displayed behaviours of distress and physical aggression towards staff and other people while they received personal care. The records stated a psychiatrist had visited to ascertain the person's level of need, and if they needed to be 'sectioned'. On this occasion, the psychiatrist assisted staff to change the person's clothes. However, no documentation was made of strategies used, techniques applied, or lessons learned to assist staff next time an incident occurred. The impact of this meant the person could potentially hurt themselves, put other people at physical risk including staff in the future.

We observed six people appearing distressed during the course of our inspection. Staff had not been equipped with appropriate skills to deal with the level of distress people were experiencing. This posed a risk to the person and to staff.

We observed three people who had been identified as at risk from falls, walking around in either socks or slippers that were not secure and may not maintain their physical safety, increasing their risk of falling. One

person, who we were told was usually mobile, was in their armchair in their bedroom when the cleaner washed the vinyl floor. The person was in their socks, and had they got up for a walk may well have slipped and suffered injury.

Risks to people's skin integrity were not always fully assessed or acted on. For one person, with risk of pressure areas, a pressure relieving mattress had been identified as required but no pressure relieving cushion for use on chairs, thereby increasing their risk of pressure areas developing.

There were multiple people who remained in bed for most of the day. These people had been assessed as being at risk from social isolation and at risk of not being able to keep themselves appropriately hydrated. We found that these people either could not use their call bell or did not have their call bell within reach. These people's care plans did not include how often they should be checked to ensure their wellbeing. We asked staff to attend to three people because staff walked by the person's closed bedroom door without checking on them. Staff told us the people concerned called out if they needed something. We asked how staff would know when the person genuinely needed assistance and they said that they would not. After we highlighted this, the registered manager updated peoples care plans to ensure routine staff checks were introduced and these were to be documented. However, the risks associated with people being unable to use a call bell had not been properly assessed or minimised.

The registered manager had not done all that was reasonably practicable to mitigate risks to people's safety because care records lacked detail and monitoring was not always effective. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For some people some risks were identified and planned for. For example, in relation to their weight and skin integrity or risk of falls. Risks to people's safety had been assessed in regards to mobility. Mobility assessments included details of specific tasks such as 'sit up in bed', 'turn/roll in bed', 'sit/stand', 'walking', 'toilet', 'dressing' including where people could manage independently and when staff were required to support. Mobility aids that people required to promote independence were clearly recorded. Where people required the use of hoists, details of the specific equipment and sling size were recorded. We observed staff supporting one person to transfer from their wheelchair to an armchair using a stand aid. This was carried out safely, with guidance and reassurance provided to the person. A staff member said, "We always make sure the environment is safe prior to a transfer. If someone is assessed with needing the use of a hoist we work in twos".

People and their relatives told us they were safe from abuse and neglect. One person told us, "It's safe, secure and comfortable." A relative said, "It's very safe." Our findings did not always support these views. Staff told us they had received training on safeguarding vulnerable adults and knew the signs to look for and what they should do. However, this was not always put into practice. We found safeguarding concerns were not always reported to the registered manager or where they were reported they had not always been addressed.

Although staff and the registered manager were able to describe the action to take in response to a safeguarding concern, we identified that the registered manager had failed to alert the local authority safeguarding team and had not notified the Commission following multiple incidences that may have constituted physical and psychological abuse. Records for one person demonstrated they frequently became distressed and physically aggressive, resulting in them harming other people. Records for multiple people who were at risk of social isolation demonstrated they did not receive frequent checks on their wellbeing that could have resulted in psychological abuse and neglect.

Unexplained bruising for two people nursed in bed had not been reported or recorded adequately and were not being tracked for healing. We found another allegation of clothing being taken from someone's room had also not been reported or acted on.

One person told us, "They rush me, hold me too tight and leave me with bruises." The person's relative confirmed, "They are quite rough with [named person]. There just isn't enough staff."

We found staff had used physical interventions on a regular basis when supporting two people., One of which had recently left the service and was now residing elsewhere and it was recorded they were distressed each time. The physical interventions used had not been appropriately sanctioned, via the use of mental capacity legislation, as the least restrictive option regarding the person's care and support, which, we have expanded on in the 'effective' domain. There was no information in the person's care plan to guide staff in how to support them with their behaviours. Meetings with professionals had been held but no record of their advice was included in care plans. There was no record of physical intervention training for staff, which included the use of holding techniques. The home had reported to the person's social worker in a review prior to our visit that they were using physical intervention without having been trained. We spoke to the person's social worker who confirmed this and stated they were under the impression the team of staff would be trained without delay. The registered manager confirmed this was not possible. The registered manager gave assurances all physical intervention would immediately seize and stated they were unable to meet the person's needs. As a result, the person was given notice and following our inspection was rehomed by the local authority. We discussed these concerns with the registered manage, and as a result reported all of these concerns to the local safeguarding team for investigation.

The failure to take the necessary action of informing the local authority safeguarding team in line with local protocols was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staffing levels on the first day of our visit. Members of staff told us they felt there were adequate staffing levels. Rotas reflected that Monday to Sunday there were five care staff and one nurse between 7am and 1pm, four care staff and one nurse between 1pm and 7pm and two care staff and one nurse from 7pm to 7am. In addition to this, there was one chef and a kitchen assistant who worked, from 9am either to 1pm or 9am to 3pm Monday to Sunday.

A relative voiced concerns about the level of staffing and told us, "I don't think there's enough staff on. Today my [person] has had to wait over an hour on the toilet." People told us there were not always enough staff to meet their care and support needs. One person told us, "No, there is definitely a staff shortage. The carers are just run ragged." Another person commented about staffing levels, "There's a shortage all the time, you never see."

Staff could not monitor people living in the home effectively and they were over stretched with the workload. Throughout the inspection, we noted people were left in the lounge areas unattended for long periods. People with needs related to dementia and mobility were unable to get the support they required. We observed a person drop their drink on the floor in front of them, in attempting to pick this up there was a risk of falling and no staff to respond to this. Other people appeared confused and distressed and there were no staff available to provide reassurance or support. The staffing levels were not effective in ensuring people received the support they needed in a timely way. At one point, we observed a person having to wait over one hour for support to get off the toilet.

We discussed our concerns about the lack of staff with the provider and registered manager at the end of the

second day. They agreed with our concerns and arranged for more members of staff to be placed on duty urgently. Following our inspection, the registered manager had reassessed the needs of people at Burlington Nursing Home and gave assurances that the staffing levels had been increased by an additional two hours per person, per week who received care in bed. The registered manager told us, the additional increase would mean people who spent most of their time in bed, would be better supported emotionally and physically. This also meant the service was enabled to be more flexible to meet people's needs.

Failure to ensure that there are sufficient numbers of staff to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager told us that they had addressed a number of the issues and concerns identified. However, we were unable to verify this or their robustness. We were aware of the action plan the home had started to work on, as part of the registered manager's concerns process in relation to the documentation of risks and people's care plans. The registered manager told us that supernumerary hours had been given to some staff to update the care plans and risk assessments.

People's medicines were managed safely. The nurse was able to explain the provider's medicines policy for reporting medicine errors and records showed that staff had received training in how to manage medicines appropriately. Medicines were stored safely in a locked cabinet. There were suitable arrangements for medicines, which required chilled storage in order to remain effective, and records showed that medicines were stored at the appropriate temperatures. There were five registered general nurses (RGN), one of whom was the clinical lead who conducted monthly audits. This is to check that people had received their medicines as prescribed. When audits identified that staff had on one occasion, failed to sign that they had administered medicine, the registered manager had taken action to address this with the staff concerned.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal record checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk. For overseas staff, their eligibility to work in the UK was checked prior to appointment. The service maintained a check on the professional registration of its registered nurses with their professional body. A copy of their current registration was in their staff files.

Equipment maintenance and service checks were completed at regular intervals to ensure people were safe from risk. These included fire equipment checks, legionella, water temperatures, gas, electrical equipment and installation and checks on hoists.

Moving and handling equipment such as hoists, bed rails and sensor mats, call bells and fire safety items and systems used in the service were well-maintained and serviced appropriately. Maintenance personnel carried out checks on hot water outlets and fire alarms. They were available to make repairs to items when required.

Requires Improvement

# Is the service effective?

## Our findings

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 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 so that they can 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 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. We found exampled where the registered manager was working within the MCA principles and where DoLs had been sought and authorised. However, we also found consent was not always sought in accordance with MCA and its principles were not always followed where people lacked capacity to give consent.

For two persons, although one of those people had recently left the service prior to the inspection, there was no documentation to demonstrate who had made the decision and who had contributed to the decision; of physical intervention being used. There were no records noting what discussions had taken place in regards to using physical intervention and about how care was to be carried out using least restrictive options and whether physical interventions would be required. A DoLS had not been applied for due to no capacity assessment being completed. This meant the physical interventions carried out by staff were unlawful.

We observed one person being supported by staff to sit in a recliner chair, who was able to walk. We observed the person remain in the chair for over two hours. We brought this to the registered manager's attention and asked if the person was able to operate the chair to allow them to stand. The registered manager confirmed they were unable to and agreed that staff had supported the person to sit in the recliner chair to restrict their freedom of movement. The person is known to shout out, which can distress other people and staff confirmed that is why they had supported the person to sit in the separate lounge area in the recliner chair to prevent them from entering the communal lounge. We identified six people whose rights may not have been protected because the registered manager had not assessed their capacity to consent to receiving care in bed and had not considered whether they had their liberty deprived unlawfully.

The risk assessments in place did not always consider if people were able to consent to these measures or whether a less restrictive practice could be used.

Not acting in accordance with MCA and DoLS with regards to intending to control or restrain a person that may not be a proportionate response to, a risk of harm posed was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staff had received training in MCA/DoLS but there were concerns some staff did not fully understand the

legislation. Staff had not completed training in how to manager behaviours that may challenge or how to manage physical aggression. Which, meant staff were not provided with skills in how to divert people's attention and deflect oncoming blows. Records demonstrated there had been times when staff carried out physical interventions with people, which placed both the person and staff at risk of harm and were unlawful. In discussions with staff, they described the use of holding techniques when supporting specific people but there was a concern that they did not fully understand that their actions in supporting them constituted a physical intervention or 'restraint'.

Staff were supporting multiple people who was experiencing heightened anxieties. Some staff told us they felt ill equipped to deal with the more complex challenging behaviours that the people experienced and their training did not cover all the areas they required.

In addition, the skills mix of staff were not suitable to meet the needs of people living at the home. Although most staff had completed training in dementia, the training provided was a short course, not adequate for the staff to understand how to support the large number of individuals living with dementia. This was evident in the way people were supported and spoken to during our visit.

Another CPN told us, "From what I observe when I go into Burlington there is a lack of an understanding of dementia by the care staff."."

Not ensuring staff fully understood the training they received and carried out their duties in a competent way was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

People were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs. New staff were required to complete the Care Certificate, a nationally recognised set of standards that health and social care workers adhere to in their daily working life. This covered 15 standards of health and social care topics.

We viewed the training records for staff; which confirmed staff received training on a range of subjects. Training completed by staff included, moving and handling, health and safety, infection prevention and control, safeguarding, medicines, food hygiene, first aid, equality and diversity, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff felt supported in their roles and received regular supervision. One staff member said, "I've had loads of support and supervisions". Records confirmed that staff had attended regular supervision meetings and an annual appraisal with their line managers. This provided an opportunity for them to discuss achievements, concerns and professional development.

People enjoyed the food at the service. During lunch, we heard comments including, "This is very nice", "It was delicious". The chef explained that they used a three-week menu, which consisted of two main meal choices and changed with the seasons. In addition, there were special menus for celebrations such as Christmas and St. Patrick's Day. People had the opportunity to make suggestions at residents' meetings or directly to the chef. We observed that people were asked for their choice of meal during the morning and that this list was then passed to the kitchen. A pictorial menu was available to assist people in making choices but we did not see this in use.

When a person moved to the home, they were asked about their dietary needs and preferences. In the kitchen, there was a reference board, which detailed specific needs such as, diabetic, vegetarian, no pork,

fork-mashable or pureed diets. Where staff had concerns about a person's ability to swallow safely, referrals had been made to the Speech and Language Therapist (SALT). Recommendations of food and fluid textures had been incorporated into people's care. Where people needed aids such as plate guards, adapted cutlery or beakers to help them manage to eat and drink independently, these were available.

The mealtime experience in the main dining area was positive and enjoyable with plenty of conversation between staff and people themselves. A food diary was maintained for people who were at risk of malnutrition and weight loss. This was completed in full by staff on a daily basis and detailed what had been offered and how much was consumed.

People told us they saw the dentist, doctor or chiropodist when they needed to and we saw records were made of the advice provided. These included the dentist, GP, podiatrist and dietician. The GP and paramedic practitioner who visited people at the service told us that they received timely and appropriate referrals and felt that staff were knowledgeable about the needs of people they supported. The paramedic practitioner told us, "People are looked after really well, I visit weekly. There is good leadership. There are pockets of good care. Quite often staff will call and will ask for visits proactively. Fluid charts can be hit and miss but things have been better recently."

Requires Improvement

# Is the service caring?

## Our findings

We received mixed feedback regarding whether people, relatives and healthcare professionals felt that Burlington Nursing Home offered a caring service.

A nurse told us, "I would not say that I found the home to be caring, there was a man in a wet/soiled pad, who appeared to have been in this state for some time, but staff left him in this state due to his aggression, however, myself and the Consultant Psychiatric Nurse (CPN) would have questioned a best interest decision to help make him clean, tidy and maintain his dignity."

A CPN told us, "I had to look around to find something for [named person] to do. I was only able to find a small doll for her. When I handed this doll to [person], she reacted straight away by cuddling the doll and talking to the doll. I informed the carer that [person] had been very distressed when we arrived due to this other female resident. The carer just looked at me and said she is like that with any resident. There was no compassion or understanding from this carer and she walked away."

We observed instances when the staff approaches could be improved to ensure consistency when supporting people. For example, an inspector had knocked and entered three peoples bedrooms with the registered manager to speak with them and noted their sheet was ruched up and they were lying half on the plastic mattresses. Members of staff had arrived shortly beforehand to support these people with their lunches but were unable to evidence they had checked with each person if they were comfortable or whether they wanted the sheet adjusted. It also could not be evidenced when people who spent the majority of time in bed – when they were offered drinks and when their wellbeing was checked. The registered manager immediately created checking forms for those who spend time in bed to ensure these areas where checked regularly and documented.

Interaction between people and staff across the service was observed to mostly be limited and task focused. We observed some staff ignore people who attempted to interact with them, or, acknowledged them but not stop to converse or find out what they wanted.

We also observed many occasions when staff treated people with dignity and respect, offered choices, spoke to them in a kind and patient way and comforted them when they were upset. For example, staff assisted people to eat their meals in an appropriate way, they offered several choices of meals, some of them visual, when options were declined and asked them if they wanted second helpings of each course. Staff assisted people with their mobility when required and ensured those who were independent were supervised from a distance. Staff ensured items were within people's reach when they were sat in bed or in a chair in their bedroom. We saw staff adjusted people's clothing when required in a discreet way. During administration of medicines, the nurse spoke to people, explained what they were doing, engaged with people using their first names and used different approaches for specific people indicating to us, they knew their needs well.

We observed one staff member encouraging a person while they were using a walking aid, stating, "Take

your time . . . you're doing well" and placing their hands on the person's arm in an encouraging way. We observed staff using a gentle and reassuring touch on people's hands and shoulders, which people responded positively to.

People told us staff were kind and caring towards them. Comments included, "They are nice carers, kind and patient", "The staff are all helpful and listen", "I'm looked after well."

A relative told us, "The staff are very kind, very helpful, cheerful to the people they support. I've been coming here nine to ten months." Another relative told us, "Staff understand [person]. The staff have always been pleasant and respectful. [Person] seems really happy here".

We were told there were no visiting restrictions in place. Three relatives told us they were always welcomed when they visited and encouraged to take an active role in their relative's care. We saw staff greet relatives in a way that indicated they knew them well and had developed positive relationships. We observed relatives visiting at varying times during the day. Staff had encouraged people to maintain relationships that were important to them. All four relatives told us they were generally updated about any changes to their family member's care and that they were invited to any reviews of the care plans.

Although the records did not evidence that people had been involved in planning, reviewing and evaluating their care, people told us that they were quite happy. They said that staff involved them in decisions relating to their daily care and how they wished to spend their time. During our visit, we observed staff offering people choice and respecting their decisions, such as on whether they wished to participate in the activity taking place in the lounge, or on what they wished to eat and drink. Staff described to us how they made sure people had a say in their care.

People who used the service were provided with information. There were notice boards containing information about who was on duty, what activities were planned and what the meals were for the day. There was a service user guide, which described the services available and how people could raise concerns. We observed staff provide people with explanations prior to carrying out tasks such as moving and handling or supporting them with meals. These measures helped to keep people informed and enabled them to make decisions about their daily living activities.

We looked at comments from compliments cards and saw these indicated staff had shown compassion and kindness to people who used the service.

Staff maintained confidentiality. Conversations about personal issues or phone calls made with professionals were carried out in the office. Staff files were held securely in the main administration office. Care files were held securely in lockable cabinets and cupboards.

Requires Improvement

# Is the service responsive?

## Our findings

We found that people's care records were standardised across the service with little evidence of personalised care. People's life history had not always been completed, and, particularly for those people living with dementia, this could affect staff ability to understand and communicate with them.

A CPN told us, "Care plans do not always seem to reflect individual person centred care."

Care plans did not always reflect the assessed needs of people who used the service. Care plans lacked detail, were not always person centred, had not been reviewed when needs changed and lacked goals for individuals. Assessments and care plans were not being completed or reviewed by staff with the skills, competence and experience to do so. Care plans and assessments were of a poor quality and routinely reviewed stating 'no change' even when changes had occurred during the review period. This meant staff had limited information about people's needs and there was a risk that people may receive inappropriate care. We found that there was a lack of management oversight for staff within the service to ensure that they were following care plans and understood people's changing needs.

Where people displayed behaviour, which may be challenging they did not have any positive behaviour support plans in place, which detailed what behaviour may be displayed. The plans did not provide guidance for staff on how they should respond to behaviours displayed to reduce the likelihood of the person becoming upset. The plans did not detail triggers and early warning signs and lacked details for staff in early intervention strategies. There was no guidance around recovery phases and what should be observed after an incident. There was no guidance on how to use post incident strategies to support the person to remain calm. The impact of this meant people were not being appropriately supported in a personalised, skilled and proactive way around their behaviours and complex needs.

We identified six people being at risk of social isolation. Not all of these people had care plans that stated they were at risk of social isolation and should be included in activities. We observed these people were left alone in their room for many hours during both days of our inspection. We checked the activities log and the information was brief and could not evidence that any meaningful interaction had taken place for these people. Therefore, it could not be assured that this need was being met consistently and in line with their care plan, for those that had one.

We looked at how people's care was evaluated each month. Staff commented on changes that had occurred but this was not consistent and some evaluations missed reporting on incidents the previous month. The information in evaluations was also not always updated in the care plan so staff would have to read through pages of evaluations to see when changes had been made. Similarly advice and treatment from professional visitors such as G.P's, psychiatrists and speech and language therapists was included in 'professional visitor's logs' or letters following visits, but the information was not always added to the care plans. This meant there was a risk of updated information about care and treatment not being readily available to staff in care plans.

Records of activity for people did not demonstrate that they received regular stimulation or opportunities to participate in activities. The registered manager told us that all activities were documented. Records showed that for one person their last documented activity was in May 2016. For another person it was in June 2016. One person who spent the majority of time in bed, told us, "No I don't like living here. I'm bored. I spend all the time in bed." The person did not have their radio on or TV. The person told us, staff only came in when they called the bell. The person told us, "The staff don't want to talk to me, they are too busy". Similarly, for people who were cared for in their rooms, there was little evidence to demonstrate that they received opportunities for social interaction outside the delivery of care. In people's care records, there was limited information regarding their life story, hobbies or interests that could potentially be used to good effect by staff in providing activities and meaningful occupation.

A CPN told us, "There is a lack of stimulation for the residents."

Another CPN to told us, "I believe the residents are bored ", and went on to say, "This [person] appears to be bored, no stimulation and I do not believe she has been out of the care home for a very long time."

For meeting the needs of people with dementia the service offered little in the way of objects or activities to aid reminiscence to help engage people in conversation. Staff were busy and had very little time to spend with people in communal areas.

Not ensuring people's needs were assessed and care was planned and delivered in a consistent and person centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We also found examples of personalised care plans. Before people moved into the home, they had received an assessment to identify if the provider could meet their needs. This assessment included the identification of people's communication, physical and mental health, mobility and social needs. There was a 'personal profile, which contained basic information about people and asked questions such as: 'Who are the most important people in your life, what makes you angry/happy/sad?' Following the assessment there were some care plans, which had been developed with the involvement of the person concerned and their relatives to ensure they reflected people's individual needs and preferences.

In discussions, staff were knowledgeable about the individual preferences and needs of each of the people staying there at the time of this inspection.

For people who were able to access the communal area, there was a varied activity programme on offer. There was an activity coordinator who worked in the home 9.30am to 21.30 Monday to Friday each week and had developed a daily programme of entertainment including music, quizzes, memory games and having nails painted. In addition, visiting entertainers had been booked to deliver musical entertainment, an exercise class called music and movement and a hairdresser visited each week.

On the day of our visit, approximately six people remained in the lounge. The radio was on and the TV. People were knitting and doing puzzles. There were blankets on chairs in case people got cold.

People were supported to maintain relationships with their families. Details of contact numbers and key dates such as birthdays for relatives and important people in each individual's life were kept in their care plan file. People told us staff helped them to keep in contact with their friends and relatives.

Handover records sampled showed entries were completed by staff twice a day between 7am and 7pm.

Handover records demonstrated that when staffing teams changed shift, people's needs were discussed such as their health and their mood. This helped ensure people's needs were monitored and that all staff were aware of any changing needs. At the handover meeting, a nominated staff member on each shift recorded what each person had done that day. It detailed what else was planned, a reminder for staff to read the house diary for appointments and the name of the nurse who was nominated to administer medication. Daily records compiled by staff detailed the support people had received throughout the day and this followed the plan of care.

People were invited to share their views during regular informal resident meetings. We saw that the menu and activities were regular features on the agenda and that both the activity coordinator and chef were invited to attend these meetings so that they could respond to any questions and act on suggestions. People told us that they felt able to speak with the registered manager. Some relatives had attended individual meetings with the registered manager, which were recorded. Suggestions from these meetings, such as for a person wanting to see the hairdresser more regular had been acted upon.

There was an effective complaints system available and any complaints were recorded in a complaints log. There was a clear procedure to follow should a concern be raised. People told us they were aware of the complaints procedure and knew what action to take if they had any concerns. The provider's complaints policy and procedure helped ensure comments and complaints were responded to appropriately and used to improve the service.

A relative told us, "If I had a complaint, I would speak to [registered manager]. She is very helpful"

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager had failed to notify the Commission of specified incidents that are required by law. We found that authorisations of DoLS had not been shared with us and that multiple episodes of what could constitute as abuse not reported.

The registered manager had failed to act in line with their legal responsibilities. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

We found shortfalls in management knowledge about mental capacity legislation, consent and physical interventions.

People gave us mixed feedback about the management of the service. Three people and two relatives told us they thought it was well managed. One person told us, "It's well managed", "[registered manager] has a tough job and I think she does it well. She keeps the staff in line." A relative said, "[registered manager] is approachable. She resolves issues quickly". However, two other people and two relatives expressed dissatisfaction with how the home was run. One person remarked; "Management could be better." Another person told us, "It takes too long for concerns to resolve. [registered manager] says one thing and the staff do another." A relative said, "The home needs more staff and this is obvious, I don't understand why there is such a small number of staff on duty."

A nurse told us, "I would struggle to say the home was well led."

A CPN told us, "This care home is not well led."

Systems to monitor and manage risk were not effective. On a monthly basis, the registered manager completed an audit covering an inspection of the premises, accidents and incidents, complaints and infection control. There was weekly medication audit and hoist slings were checked each month to ensure that they were in good condition and safe to use. On a monthly basis the registered manager sampled care plans and staff files. For each of these audits an action plan had been drawn up and used by the registered manager to make the suggested improvements. For example, people at risk of falls were referred to the falls prevention team for additional support and guidance. Two people who needed to new pressure relieving mattresses were replaced. Although the registered manager and provider had a quality assurance system in place, it had not been effective in identifying their failure to comply with the requirements of some regulations as identified in this inspection report.

Accurate records in respect of risks for each person were not always maintained. We found care plans did not always accurately reflect people's needs. For example, on two occasions, one person was recorded to have been sexually inappropriate towards staff, but the person had no care plan or risk assessment relating to this. Body maps for some people were found but no records of monitoring or progression of their wounds was located. Records to monitor risks of falls were not always completed or totalled to identify if any action was needed.

Most people told us their call bells were not always answered promptly. One person said, "We wait a minimum of 15 minutes to an hour." Another person commented, "It can vary sometimes five minutes, or longer." A third person remarked "At night they come very late." We asked to see a print out of the call bell response times. The registered manager confirmed they were not using the call bell system to check call bell responses to establish if there were any delays or any problems in the system. We identified from the print out, during a seven day period, there were 37 occasions where people had to wait between 11 minutes and 50 minutes for staff support. On one occasion, a person had to wait three hours. We also identified a pattern that there were four particular people this impacted. There was no system to identify and highlight that some people did not receive prompt attention.

These issues were all in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Communication among some of the staff and nurses did not appear to be effective. The registered manager had not been made aware of some safeguarding issues and risks that were known to other staff. In response to not being kept up to date by the clinical lead, who was a registered general nurse, the registered manager and provider met during our visit to reassess the structure of management. We met with the clinical lead who confirmed information that should have been passed to the registered manager hadn't been. We met with the registered manager and provider at the end of our visit who gave assurances that they were restructuring their team with immediate effect. The registered manager told us, she had promoted an experienced carer to deputy manager and had taken over the clinical lead role herself. The deputy manager was tasked, we were told to concentrate on the personalisation of care being offered and to update monitoring forms, for example for people who spent more time in bed, to include what social stimulation had been offered, was the person offered a drink, offered something to eat and to check the person was comfortable. The registered manager told us, that by doing the clinical lead role herself, she would have better oversight of peoples health and behavioural needs.

Each time we informed the registered manager of our findings, she immediately responded by ensuring shortfalls were addressed. This included informing the safeguarding team of concerns, notifying staff that all forms of physical interventions were to stop, arranging staff meetings to offer additional support and guidance and updating the services audit tool to ensure the areas we identified would be included. The registered manager recognised she was unable to offer particular people a high quality service and served notice on two of those people to find them alternative accommodation.

Regular resident or relative meetings occurred to gain views about the quality of the service. We read minutes of group meetings with staff and people. These recorded that the registered manager invited people to speak with her openly at any time with any concerns or queries. The registered manager told us that she worked flexibly; to give working relatives the opportunity to meet with her face to face and in private, which relative confirmed. Some people had asked at the resident meeting for an improved activity programme and this had been provided.

Surveys had been completed in September 2016 to measure the opinions of people, their relatives and staff. Results had not yet been analysed. There were 13 relative responses. Feedback overall were all very positive. Comments included, "Management is excellent", "[registered manager] is very good". "Management is very understanding". Other comments included, "waiting time for residents who need the toilet more often should be addressed. Residents can be kept waiting".

Staff said that good teamwork is crucial in moving forward. Staff told us that they felt able to speak frankly with the registered manager with any concerns about the service and understood their responsibility to

whistle blow if necessary. Comments included, "I am supported in my role, very much so." "Absolutely feel supported." Supervision sessions had provided another opportunity for staff to give their opinions and the registered manager had produced action plans based on comments arising from those meetings.

The manager is a registered nurse and told us how she kept informed about best practice within health and social care through local Care Forum meetings and attending training and development conferences when possible. The provider visited the service at least once each week to support the registered manager. The registered manager said she felt supported by the provider and able to raise any issues with them openly.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The Registered Manager had not ensured that CQC were informed of all relevant and notifiable incidents as required under this regulation.<br><br>(1) (2) (e) (f) (g) (i) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The Registered Manager did not ensure that service user's care and treatment was appropriate, met their needs and reflected their preferences. Care was not always designed to ensure service users' needs or preferences were met or that they understood the care and treatment choices available.<br><br>(1) (a) (b) (c) (3) (a) (b) (d) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered manager had not assessed the risks to people who used the service or looked at how they could be mitigated.<br><br>(1) (2) (a) (b) (c) |

| 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<br><br>The registered manager did not have systems and processes that effectively operated to investigate and report allegations of abuse. Care and treatment was provided in a way that included acts intended to control and restrain a service user.<br><br>Service users were not protected from being deprived of their liberty.<br><br>(1) (2) (3) (4) (b) (c) (d) (5) (7) (a) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered manager and provider had not established effective governance systems to assess monitor and mitigate the risks relating to the health, safety and welfare of service users.<br><br>The registered manager had not maintained securely an accurate, complete and contemporaneous record in respect of each service user.<br><br>(1) (2) (a) (b) (c) (d) (e) (f) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered manager and provider had failed to make sure there were sufficient numbers of suitably qualified, competent and skilled staff.<br><br>The registered manager failed to ensure staff received appropriate training to enable them to carry out the duties they are required to perform.<br><br>(1) (2) (a) |