Burnham Lodge Limited

Burnham Lodge

Inspection report

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Date of inspection visit:
17 December 2018
20 December 2018

Date of publication:
06 June 2019

Ratings

Overall rating for this service	Requires Improvement

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

This inspection was completed on 17 and 20 December 2018, by two inspectors. The inspection was unannounced, which meant the provider did not have any advanced knowledge of the date of the visit.

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

Burnham Lodge can accommodate a maximum of 60 people in the premises with 49 bedrooms, and the remainder as day patients. At the time of the inspection 36 people were using the service which is operated from a large stately home set in vast acreage. Four floors offer bedrooms and facilities, including a hair salon, large communal dining areas, an activities room based in the conservatory and a large day room. Each bedroom is en-suite with additional toileting and bathing facilities offered per floor.

The service has a registered manager. However, at the time of the inspection, the registered manager had been on maternity leave for 11 months. The service was overseen by the deputy manager, and a peripatetic management team. 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.

People were not kept safe. Adequate risk assessments and comprehensive documentation were not in place to ensure people were offered responsive, safe care and treatment. Staff could not always tell us how to safely care for people and meet their needs, and people's care plans and risk assessments contained conflicting and inaccurate information. The inconsistent information meant people were put at risk of harm.

Medicines were not always managed safely. Whilst we found that medicines were stored in people's rooms, temperatures were not maintained, therefore were at risk of the efficacy of medicines became altered. Furthermore, the method of administration was not in line with best practice guidance, or with the provider's own medicine administration policy.

People were not being kept safe due to a failure in appropriate monitoring and recording of the environmental risks and risks to people. The service did not have robust recruitment processes in place to ensure staff employed were safe to work with people.

Nutrition and hydration records were maintained for all people. However, information was not cross referenced or analysed as required. As a result, some referrals were not made to health professionals to seek further clarity on change in people's hydration and nutrition.

Staff were not supported with adequate training, with their training not always being in date. Staff did not have training that would help them meet people's changing needs.

Effective systems were not in place to audit care documentation and identify any shortfalls in the quality and safety of care provided.

People's care was not always delivered in a dignified way. Privacy was not always protected, with bedroom doors being left open for most of the day and night. Care was found not to be responsive to people's changing needs, and often not effective. People were not always consulted about how they wished to have care delivered, or were not consulted prior to being assisted. This meant that whilst staff had received training in the Mental Capacity Act, they did not practice the fundamental standards of the legislation. Furthermore, people were having their liberty restricted without confirmation from the local authority that this was authorised.

The management completed ad hoc audits. The provider did not have a comprehensive overview of the service. Whilst a management structure existed, this was not effective in ensuring governance of the provision. Information was not always analysed or passed to the correct people, leading to errors in care delivery and poor management. The service, although did not specialise in delivering care to people living with dementia, had a number of people residing at the service with the onset of this condition. The service did not environmentally meet the needs of the people.

During the inspection we identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As one domain has been rated Inadequate we will inspect again within six months and if this or any other domain were to be rated Inadequate at the next inspection, the service would be placed into special measures.

You can see what action we 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 safe.

Risks to people were not appropriately assessed nor were measures implemented to keep people safe.

Environment risks were not assessed, although these presented a significant immediate risk to people's safety.

Medicines were not always managed safely.

The service did not have robust recruitment processes in place, to ensure staff employed were safe to work with people.

People were safeguarded from abuse. Measures had been implemented to appropriately investigate and monitor reported safeguarding issues.

Is the service effective?

Requires Improvement

The service was not always effective.

Appropriate measures had not been implemented to ensure people's hydration needs were met, due to poor recording, documentation and follow through.

The service failed to cross reference records and make referrals as required to health professionals.

The service although catered for people with dementia, did not fully meet their needs. The environment was not appropriately designed to meet people's needs.

Staff training was insufficient to safely and effectively meet people's changing needs.

The service had not ensured that all application of DoLS were followed through. This meant people were being restricted of their dignity without legal confirmation this was acceptable.

Is the service caring?

Requires Improvement

The service was not always caring.

Privacy and dignity was not always protected, with doors being left open.

There was insufficient evidence to illustrate people were involved in their care development.

People were not always communicating in their method of choice. Staff were not fully aware what this was due to poor documentation.

Confidentiality was maintained. A secure IT system was used that enabled information to be saved securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not reflective of their changing needs.

People did not have all their personal care needs met.

Appropriate alternative measures had not been put into place to manage and respond to people's needs as and when these arose.

Complaints were appropriately managed and recorded.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Effective processes were not in place to monitor the quality and safety of the care provided. Where the provider had identified shortfalls, such as unsafe medicine administration, action had not been taken to mitigate the risks.

The provider had not ensured people's care plans and risk assessments were complete and accurate. Audits of documentation associated with people's care and treatment had not taken place.

Leadership of the service was not always due to inconsistency in management.

Burnham Lodge

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 was carried out after 12 months of a new provider taking over the registration of the service. The CQC complete inspections within 12 months of a newly registered provider or location commencing a regulated activity. This is to ensure that the requirements of legislation are being met. This inspection took place on 17 and 20 December 2018 and was unannounced. The inspection was completed by two inspectors over both days.

During the inspection process, the local authority care commissioners were contacted to obtain feedback from them in relation to the service. In addition, we sought feedback from health care professionals involved with the service. We referred to previous inspection reports, local authority reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, this is a legal requirement. As part of the inspection process we also look at the 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 had received the PIR for Burnham Lodge and used this to help inform our inspection plan. During the inspection we spoke with 11 members of staff, including, the peripatetic manager, the deputy manager, two senior management staff, the activities co-ordinator, the maintenance person, two registered nurses and three care staff.

We used the Short Observational Framework for Inspection (SOFI) during lunch. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interactions between staff and people living in the home throughout the day, both whilst giving support and during general interactions.

Care plans, health records, additional documentation relevant to support mechanisms were seen for seven people. In addition, a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. Staff recruitment and

supervision records for six of the staff were looked at. As part of the inspection process we completed observations during the day, as well as seeking feedback from relatives during the inspection process.

Inadequate

Is the service safe?

Our findings

Medicines were not always managed safely. The home had taken steps to promote a homely environment. However, where medicines were retained in locked cabinets in people's own rooms, rather than in a medicine room or trolley, adequate steps had not been taken to consider the issues pertaining to storing medicines at a safe temperature. We found that some cabinets were hung near radiators. Whilst room temperatures were recorded these were not representative for the whole day. For example, we found that during the lunchtime medicine round, the cabinet temperature was in excess of 26.5°C. Most medicines require being stored below 25°C. Medicine efficacy can alter with temperature variation, and temperatures above the stated safe storage temperature. Checks on temperature were completed once only, during the morning, where outside temperature will be at its coldest, affecting the internal room temperatures.

In addition, we noted that medicines were not managed in the safest way during administration. In two separate examples, we observed unsafe practice. The first involved administration of a medicine that was subsequently declined by the person. This was then placed back in the person's medicine cabinet, within a pot, rather than destroyed. In a separate incident, we observed a member of staff approach a person sitting in the dining room, and asked if they would like their medicine. The person confirmed. The registered nurse went to the person's room crossing several corridors, administered the medicines into a small medicine cup and returned with the medicines. The person had neither seen the staff administer the medicine from the boxes, neither were medicines given separately to allow the person to refuse specific medicines. This practice was against company policy, that stated medicines needed to be administered in front of people.

Medicine competency assessments were completed for all registered nurses on an annual basis. This enabled the provider to be assured that staff were able to safely administer medicines. However, we found that one competency assessment from 7 December 2018, raised concerns that a registered nurse did not check the medicines against a Medicine Administration Records sheet (MARs), and administered medicines that were not to be administered together. This potentially put the person at risk of harm. This registered nurse was still involved in administering medicines. There was no evidence of, nor could the management advise what action had been taken to mitigate a similar risk. Subsequent to our inspection, we received information from the Clinical Commissioning Group (CCG). This was in relation to good practice in managing medicines safely. We were told the Pharmacists within the CCG will continue to work with the service to improve the management of medicines.

During the first day of the inspection, a tour was completed of the service. This highlighted a number of significant safety issues, many of which put people at the potential of immediate risk of harm. We found call bells in communal bathrooms were tied up out of people's reach. Where button call bell systems had been installed, these were located on opposite walls and too high. This meant people and assisting staff were unable to call for assistance should the need arise. Some people within their rooms did not have call bells within easy reach. We raised this with the management, who acknowledged this was unsafe practice. However, during our second day of inspection we noted no measures had been taken to mitigate the risk; call bells remained tied up.

We found that the environment people lived in was not safe from risks. For example, we saw on day one of the inspection that a section of carpet had been removed from the basement corridor where some bedrooms were located off. The carpet strips remained in place along the sides of the corridor. These were spiked so to hold the carpet in place. A sluice room was being used as storage for sharp tools and work equipment, however the door was left open, enabling people to access the room. The removed carpet was placed at the bottom of the stairs creating a trip hazard for anyone who was using the stairs to go up or come down. The lighting in this area was also insufficient.

We spoke with staff regarding our concerns, querying when the carpet had been removed, and requesting to see the risk assessments. We were advised that whilst the carpet had been removed over two weeks' ago, no assessments had been completed to assess the risk. Although a number of staff had seen and accessed the corridor, including: care staff, registered nurses, domestic staff, kitchen staff, maintenance and management, no one had identified the potential environmental risk to staff and people. The carpet and strips were removed as a result of the concerns raised. The sluice room door was pulled to, however remained unlocked and accessible during both days of the inspection.

The building is an old stately home, that the management team stated would require significant financial input to maintain the building, and to bring it up to standard. The dining rooms had recently been refurbished, with people providing input into décor and style. Bedrooms, and en suite bathrooms were also being scheduled to have work completed over the next 12 months. Bathroom doors were being painted yellow, to allow people to easily distinguish between all the doors, as signage was not currently used. However, we found a number of concerns relating to the deterioration of the building. This included: black mould in communal corridors, carpets being extremely tired worn away (therefore becoming potential walking hazards). We saw sections of the building where work had been completed, but holes had been left in walls enabling access to live wires. These hazards have the potential of dangerous implications upon people and staff's health. Whilst it was recognised that the vast size of the home bore financial implications on the provider completing works, it was unacceptable to allow poor workmanship.

People were not always being kept safe by staff at the service. Whilst some of the risks were not imminent, they were consistently present in different aspects of the care provision, which could lead to serious concerns related to people's safety. We spoke with staff to ascertain their understanding of how risk was managed and measured and were referred to the use of risk assessments. A risk assessment is a document that aims to provide details on how to manage behaviours or concerns that may identify as risks for people. The assessment should detail when the risk is more likely to occur, and consider measures that can be implemented to minimise the risk However, from our conversations with staff, we identified they were not always aware of people's documented risks, or that these had been assessed and mitigated for people residing at the location. This included risk of falls, urinary tract infections or skin integrity, as well as specific risks such as mental health issues or specific behaviours.

Where there were individual risks associated with people's skin health, repositioning guidance was in place for staff to follow. However, there was conflicting information on the frequency of this. One person's care plan stated, "every four hours", with the summary reading "every three hours", and the initial assessment stating "every two to three hours." The deputy manager was queried how often the person should be repositioned, and we were told every two hours. Daily records indicated repositioning was not happening within any set time frame. On occasions, the person had been repositioned every few hours, whilst on other occasions the person had not been repositioned for in excess of six hours. This was true for two other people's repositioning notes we reviewed.

In another example, we saw daily notes recorded by staff for one person who required two staff member's

support with moving and handling using specialist equipment, stated, "moved by hand by [staff name]." This was repeated over several weeks. For another two people who used air mattresses, staff were to check the weight setting twice a day to ensure this was appropriate to prevent the development of pressure damage. However, the care plan failed to document what the required setting was. When we spoke with staff they stated a weight, which was not always correct. By failing to ensure the correct weight setting for the air mattress, this placed people at risk of harm.

The majority of the people who used the service were at risk in multiple areas and risk assessments were in place. It was therefore crucial that staff were aware of how to manage these risks, as their impact may be significant for people. For example, one person who had limited verbal communication, with no mobility, was doubly incontinent and unable to alert staff to requiring a pad change. This increased the probability of developing skin problems. Similarly, a person who required food to be produced in a pureed consistency, and has limited mobility would require being positioned in a way to ensure they are able to eat their food safely, without risk of choking. Staff we spoke with were unable to consistently tell us how they managed the risks associated with these people's needs, and how they kept them safe.

We noted people had records maintained of their food and fluid intake. However, this information was not monitored to ensure people received sufficient nutrition or fluids. For example, one person was drinking between 110 - 335ml of fluid daily, across one week. There was no daily target fluid intake recorded. We spoke with the management regarding this and were told that most of the people were automatically assessed for fluid and food intake by the IT system the service had in place. However, they recognised that in these circumstances, especially as the IT system was raising an alert for staff, to seek medical assistance, nothing was being done. It was unclear if any analysis was completed, to determine where people were becoming unwell, and medical input was required.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the people were always kept safe. The provider had not done all that was necessary to mitigate any such risks related to the safe administration of medicines and preventing, detecting the spread of infections. The premises were not safe, and risks were not assessed appropriately.

People were not kept safe by the provider's current recruitment processes. The registered person did not operate effective and robust recruitment and selection procedures to ensure they employed suitable staff. We reviewed the files of six staff who worked at the service and all the files were missing some required information. Gaps in employment were not verified or checked, and reasons for employment termination were not identified. One staff did not have a photo that was up to date, and could be cross referenced across with their ID. Not all registered nurses had evidence of PINs that were in date, this information had to be located as was not within the relevant files.

The provider's recruitment practices meant people were at risk of having staff providing their care who may not be suitable to do so. This was a breach of Regulation 19 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not established and followed recruitment procedures to ensure the suitability of staff employed. Subsequent to our inspection we received information from the CCG who visited the service following our inspection. They told us that the provider had audited their staff files and were now confident the system was sufficiently robust.

Staff spoken to during the inspection could describe different types of abuse. One staff told us, "Obviously report it to the registered manager immediately." We were told that, where applicable, staff would not hesitate to whistle-blow. We spoke with the local authority safeguarding team who advised they were correctly notified of any potential safeguarding concerns. We also received notifications within an

appropriate timeframe advising of any concerns.

We noted that staffing numbers generally appeared adequate across the service. This was calculated using a dependency assessment tool based on people's needs. One staff told us, "There are generally enough staff, but of course we could always do with more". Where agency staff were used, these were consistent staff members, which meant that they knew people whom they supported well.

The provider had a business contingency plan in place detailing what action needed to be taken in the event of foreseeable emergencies. Examples included adverse weather conditions as well as staff shortage due to illness. Emergency contact numbers were included within the contingency plan, as well as what staff should do if any issues arose at the premises.

Requires Improvement

Is the service effective?

Our findings

People's hydration needs were not adequately met by the service. We looked at whether people had enough to eat and drink. During our inspection, we observed some people had drinks left out of reach and that a significant number of people were unable to drink without assistance. We looked at a sample of people's fluid intake over the course of the last seven days. We noted that no target fluid intake was noted on any of the files we looked at. Furthermore, the fluid intake was generally between 110ml – 560ml for all five people. This point was discussed with the management, all of whom were unable to advise what the target fluid intake should have been for people. We were told records were completed for all people who resided at the service, irrespective of need, by the IT system used. If certain criteria was met, the default of the system was to request staff complete hydration information. The records we looked at were specifically for people who were at risk of pressure sore development and had poor skin integrity, therefore recording fluid intake would be a necessity. It is crucial for wound healing, that people have sufficient intake of fluids. However, because no one had individual fluid targets in place based on their weight and healthcare needs, there was no way of ensuring people's individual hydration needs were met.

Generally, people were provided with sufficient food to eat. Snacks were offered during the day, as was fluid, however this was not always drunk. We noted, that the IT system had alerted staff for several of the people that "the amount [of fluid] is deemed inadequate". However, nothing was done with this information. People were not referred to health professionals. Staff did not seek assistance with ensuring people were drinking sufficient fluids to meet their hydration needs, therefore keep them healthy.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by a permanent staff team that were to receive supervisions every three months from management. New staff were supervised monthly. Staff told us that whilst supervisions had not necessarily been as frequent as required, they could approach management for support. Staff training was at 80.6% compliance. 11 care staff's training in Manual Handling required refreshing, with some staff training having expired in June 2018. Seven staff's training in safeguarding had expired, with some training having expired in 2016. Three staff had not received updated Mental Capacity Act training. More than 50% of staff had not received any training in dementia awareness, care plan training and first aid. Whilst training included areas such as Equality Diversity and Human Rights not all staff were trained. Dignity and respect was not covered within the training schedule. Only three staff were trained in catheter care with two staff working days and one a night time carer. No staff were trained in diabetes, although people with diabetes were cared for within the service. The provider was therefore unable to assure us that staff had the necessary competency to safely carry out their duties.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by a staff team that had some understanding of the principles of the Mental Capacity

Act 2005 (MCA). All staff employed had received training in the MCA, as this was defined as mandatory training, however three staff's training required refreshing. The 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. We found that whilst DoLS applications had been requested as required, these had not been followed up on. 28 people were having their liberty restricted for in excess of 12 months, without management seeking to follow up on applications. This meant that the provider could not be assured that people's liberty could be restricted legally.

We recommend the provider ensures that guidelines in relation to Mental Capacity Act are followed to ensure that people are only restricted of their liberty where authorised.

Subsequent to our inspection, we received information that the provider had sought further training for staff in relation to MCA and DoLS. In addition, communication with the supervisory body had taken place for an up to date picture of the application of DoLS for the service.

During the inspection we completed observations over lunchtime. We saw staff assisted some people to eat their meals, where required. We also observed people who did not require assistance, and ate independently. We saw the food prepared by the chef was of a high standard. People commented very positively on the food quality and quantity. We saw there were two main options made available to people, with additional specialist meals prepared for people with intolerances or needing additional support. A menu board was displayed outside the dining room, and meals were discussed one day in advance. One person said of the food, "The food is exceptional! I have put on weight since living here." Whilst another person and their visitor commented, "I come to visit weekly, and am treated with the utmost respect. The food is exquisite… restaurant standard." Staff sat with people and ate during mealtimes where possible. This allowed a home like atmosphere, and enabled staff to motivate and encourage people to eat more.

The service offered support to people who required nursing care. Some of these people had the early onset of dementia. Whilst the service did not specialise in this area, we found that a number of people had begun to show signs of confusion, and the onset of dementia. The service did not have any support mechanisms to help people or redirect people to key communal rooms. For example, most doors for bedrooms and bathrooms were the same. Whilst people's names were generally written on the doors next to a room number, there was little in the way of assistance to ensure people entered the correct room. Toilet seats for communal facilities were not in a contrast colour, which could help people to locate the toilet. The communal lounges did not lend themselves to dementia care or any social participation. Seats were arranged along the perimeters, heightening the potential for poor socialisation. People were not always being engaged by the activities coordinator, who often became pulled into other tasks, such as preparing teas for people. People appeared isolated when sat within a communal setting. The corridors offered little information of interest. We found that generally there were no seats made available for people to sit in the corridors, as a place of rest, or as a place of engagement. Bedrooms were generally personalised with people encouraged to bring personal belongings and décor of their choice. However, the home did not lend itself to engaging people.

People reported staff sought consent before completing personal care, although from our observations some staff were task focused, and did not pay attention to people's responses. For example, we observed one staff member enter a person's room to assist them. They raised the person's bed, asking the person if

this was enough. The person stated, "that's fine". But the staff member continued to raise the person. When they finished the task, they left the person in the raised position, not asking them if they wished to be lowered. The person said, "They do this. Never remember to lower me, and don't listen when I say that's high enough." People told us that staff were always busy with one person or another, and often did not have time to have a chat. One person said, "I become lonely. I only see the staff when they come to my room to help me. They never come unless it's to do something and never stay to chat." We found that initial assessments had been completed in all people's records that were case tracked. However, care plans were not reflective of the initial assessments or documenting people's actual needs. Similarly, daily records failed to contain sufficient information on how support was always completed. This meant people were not always receiving effective care.

People received some effective health care and support. People could see the visiting GP and other health professionals such as physiotherapists, speech and language therapists as and when required. Although, it was recognised that at times the referral process included extensive delays, that were not directly related to the service. These potentially lead to continued health problems.

Requires Improvement

Is the service caring?

Our findings

Staff could correctly describe how they would preserve people's dignity when assisting them with personal care. Staff told us they would knock or call out to the person before entering the room, and explain what task they were going to complete. However, we observed some treatment of people that was not always dignified. In one example we observed a member of staff leave a person outside the salon. The person repeatedly called after the staff member but the staff failed to respond. We approached the person, and asked if they were okay. We found the person was seeking reassurance of why they had been left on a wheelchair outside the salon next to a dormant medicines trolley.

We noted most doors were left open with reasons being given that the person did not like these to be shut, although there was little documented evidence to confirm this in the care plans. By leaving the doors open all the time, people did not have their privacy and dignity maintained on their behalf. The service failed to consider effective ways to maintain people's dignity where necessary, when in their bedrooms.

Observations were completed during both days one and two of the inspection during lunchtimes. This was positive. People were communicated with by staff when being assisted, and generally over the meal. The experience was relayed by one person as, "mealtimes are very friendly. Staff will spend time with you and talk to you." However, staff were not always using the most appropriate communication methods will people. This was due to documents not clearly stating what these were. For example, one person's care plan read, "to maintain effective communication". However, no details were given of what this was. Staff we spoke with were unable to clearly advise what was meant by "effective communication".

We did see some evidence of caring interaction. Most staff were observed smiling throughout interactions with people and using touch appropriately to offer reassurance. Several relatives reported that the interaction was positive, however the way in which their person was supported was not always caring. They reported the staff would assist in a, "task focused" manner, ready to move onto the next person. They however, stated that this, "was not because people did not care, but because staff had to make sure all people were cared for." During activities people were not always engaged with. One person we spoke with said they were not sure why they had been brought into the conservatory. They said they had not been told what the activity was. However, did say, "the tea and cake is a lovely bonus though!"

On the days of the inspection we found people's right to confidentiality was maintained. We found staff spoke with respect and privacy regarding people. They would go to an empty room (e.g. dining room or lounge), office or stand to the side of the corridor and speak in a low tone when discussing people. Records were maintained securely on handheld devices that were accessed when care or support was being delivered. This ensured that records were kept up to date and securely.

Staff were not adequately trained in equality and diversity. This meant they may not have been aware of some best practice methods of ensuring people's needs were met equally and diversely.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. Care plans did not adequately provide sufficient information to ensure that support met the needs of people living at the service. For example, where people required two staff to support with mobilising, details were not given about which sling was to be used and how this should be done. In another example, the care plan did not document the frequency of supporting people who required assistance with incontinence.

Care plans were not always person-centred. They contained inaccurate information and did not address how the person wished to be supported. Information appeared to be sparse, irrespective of whether the person could provide it themselves or were reliant on family to provide it. All documentation was retained on a computerised system that had been in place for 12 months. This allowed staff to access care plans in hand held electronic devices, as well as enter daily records and tasks. We noted that some sections that required information had incomplete information presented. Management advised that staff were not confident using the "new" system, however, we raised concerns that as this had been employed for almost one year, staff should have been adequately trained to enter information that illustrated responsive care and treatment. Management acknowledged that care plans did not contain sufficient information and some contained conflicting information. Documented reviews were not an accurate reflection of people's changing needs. For example, one person who had lost a significant amount of weight was due to be weighed weekly. The care plan although signed off as reviewed was not cross referenced with the actions of the Malnutrition Universal Screening Tool (MUST), that identified the need for weekly weighs. As a result, the person had not been weighed as required. Staff were therefore unable to determine whether or in what way the person's weight had changed, and what responsive action was necessary.

Care plans did not demonstrate how people or their representatives had been involved in planning their care. These remained in their infancy and were recognised as a "work in progress". With staff requiring additional training on how to upload the most relevant information onto the IT systems and then use the handheld IT recording devices.

We found that staff's understanding of people's needs was sometimes lacking. For example, we spoke with several staff regarding one person who would "scream for hours at a time" and revert to their native language when distressed. We asked why this was, and what staff had done to support the person to manage their distress. We were told that this was a part of their behaviour. We read their file and proposed several reasons why the person may be becoming distressed. This was acknowledged. We queried if this had been investigated with any health professional, and were advised that whilst this person received input from the local mental health team, this area had not specifically been assessed. The information within this person's background clearly evidenced the "hallucinations" and why the person may in fact be experiencing "flashbacks".

The activities offered were not personalised to people or reflective of people's needs. Some were generic and repetitive, often geared towards group activities, rather than focusing on meeting individual people's needs. Whilst it was acknowledged that the group activities were positive and aimed at trying to include

everyone, it was recognised that not all people were able to engage.

A relative we spoke with told us, "[name] only sees staff when they are completing a task like helping to change [incontinence pads]." A person we spoke with told us, "It would be nice if they stuck their head around the corner, but I know the girls are all so busy, I try not to bother them, but feel very lonely... I'm waiting for my time now." Whilst the provider had commenced alterations to the home. There was no evidence of guidance on best practice for people living with Dementia having been sought. The staff were unaware of how to engage people informally in the course of their daily tasks. We made numerous observations during the inspection and found that staff were unaware of methods of engagement that may prove to be responsive to people's needs. For example, we saw on several occasions people seated along the perimeters of the communal lounge and in the conservatory waiting for an activity to begin. People sat in chairs were either asleep or appeared disengaged. Staff when present, smiled and made small talk, however conversations that were meaningful were infrequently observed. This meant people's social needs were not appropriately met. The activities co-ordinator arranged multiple group activities, that would involve families, however these were not always bespoke or tailored to meet individual people's needs. This was acknowledged as an avenue for further development.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not in receipt of personalised care that was responsive to their needs.

People and their families were aware of how to report a complaint or a concern. The service had documentation in place that illustrated when a complaint was received, and what action had been taken to investigate it. We found the written documentation clearly defined the process undertaken by the management when dealing with complaints.

At the time of the inspection four people were on 'End of Life' (EOL) care. Further exploration found that not all were actively EOL, however did have deteriorating health. We spoke with the deputy manager who acknowledged the IT system was not fully understood by staff which led to confusion. Staff were able to explain the necessary care for people on EOL including pain management and the use of "just in case" medication.

Requires Improvement

Is the service well-led?

Our findings

We found that the service was not always well-led. Part of the role of the registered person, is to ensure they have a full overview of the service. This is achieved through good governance. Whilst the registered provider had ensured a registered manager was in situ, sufficient and consistent cover had not been arranged over the last 11 months since the registered manager had gone on maternity leave. This furthermore included the timeframe since the new provider had taken over the operations of Burnham Lodge. This led to staff feeling uncertain about methodology of work and who specifically to approach about issues, although they were able to identify "the management".

During the inspection we found the management team were unable to answer many questions related to the day- to-day operations of the service. This was in part due to the inconsistency in management presence. It was recognised the service is large, however, it is important for the management team to have a thorough overview of the provision. The peripatetic manager acknowledged there was a significant number of shortcomings in the operations of the provision. An action plan had been created to capture areas of concern within the service. However, this was not reflective of all issues found during the course of the inspection. For example, the provider had not identified the shortfalls and risks in relation to fluid monitoring and hydration; pressure care; staff training and recruitment; person-centred care and dignity and respect.

Accurate records were not always maintained, or did not accurately reflect the support people were being offered. Care plans and risk assessments did not illustrate how changes to people's needs were being managed, if at all, and staff we spoke with could not always explain to us how to safely meet people's needs. It was unclear whether any incidents had occurred because of the absence of accurate documentation, because records were not maintained appropriately. For example, we found that repositioning charts for four people indicated that they had not been repositioned in line with their care plan, which also contained conflicting information on how often the person was to be repositioned. We noted gaps of six hours, eight hours and ten hours for one person, which were not consistent with the care plan, that documented three hours. Similar discrepancies were present in other people's repositioning charts. It was unclear whether this indicated poor recording or whether people had not been repositioned as required. We spoke with the management regarding the poor documentation to establish if this was accurate. They were unable to clarify.

There was also a risk that any new staff coming to work at the service could provide ineffective and unresponsive care, by following inaccurate care plans. We were told audits of care files and daily recordings were not completed due to the high number of people residing at the service. Although the service was large, this does not negate the provider's responsibility to ensure accurate, complete and contemporaneous records are maintained in relation to each individual's care.

Audits of the quality and safety of the care provided were completed intermittently, but these were not always effective in assessing, monitoring and mitigating the risks relating to the health, safety and welfare of people living at Burnham Lodge. Where risks to the quality and safety of care had been identified, action

had not always been taken. For example, medicine audits had indicated significant concerns. A follow up pharmacy audit raised further concerns and issues. However, the provider had not been actioned or worked upon to mitigate risk, which placed people at risk of ongoing unsafe medicine administration. Similarly, comprehensive audits of people's care documents, including daily records had not been completed. As a result the registered provider was unaware that information was inaccurate, care was not always delivered appropriately, and medical appointments were not always made as required.

Subsequent to our inspection we were told a new system and structure was in place for auditing care plans and risk assessments. We have received positive feedback from the CCG about management at the home responding positively to our initial feedback immediately following our inspection.

We were provided with maintenance records, which detailed the maintenance checks completed weekly and monthly. These were forwarded to us following the inspection. Whilst these records were in place, they had not identified the environmental risks we identified during the course of our inspection. The systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people were not effective as these significant environmental risks had not been identified.

Staff reported that the management was friendly and approachable. An open-door policy was emphasised, and staff were encouraged to speak to management of any concerns. However, staff acknowledged the service was "stagnant" and there had been little development and progress, specifically in the areas of developing staff skills and knowledge. It was acknowledged the provider was investing in the environment. However, this was phased and would cover in excess of 18 months' of work. The management team acknowledged all the issues that were identified during the inspection. We were advised a plan on how these issues were to be resolved would be developed and the return of the registered manager would enable progress to be made. It was recognised that the task ahead was difficult.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that CQC had appropriately received notification of notifiable incidents, including DoLS applications, allegations of abuse and serious injury. Where a person has sustained injury, the service is required to comply with the requirements of the duty of candour. This legislation aims to ensure that the service is transparent and reports openly on care and treatment. It further reinforces the need to document investigations where appropriate, providing an apology when things go wrong. There was evidence that this had been completed as required.

The service had not yet completed quality assurance audits or surveys, although did speak with people seeking feedback. Relatives meetings were arranged to promote openness and transparency, with relatives also invited to residents' meetings.

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 not ensured people were always kept safe. Risks related to the safe administration of medicines and preventing and detecting the spread of infection was not assessed appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The hydration needs of service users were not assessed and met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the provider to identify where quality and safety were being compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff did not have the qualifications, competence and skills necessary for the work to be performed by them.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Recruitment procedures were not established and operated effectively to ensure that only suitable staff were employed.