Care South

Buxton House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on 18, 25, 28 August 2015 and 03 September 2015. The home is a residential care home and provides support, assistance and personal care for up to 64 older people, including people who have dementia. At the time of our inspection there were 61 people using the service. The home is purpose-built and comprised of four units spread out over two floors, a ground floor and a first floor, accessed by stairs and a lift. The first floor was designated for the care of people with dementia. There was an outdoor garden space and a court yard for people to use.

The home was last inspected on the 13 May 2013 and found not to be meeting the standards in the management of medicines and assessing and monitoring the quality of the service. People were not protected against the risks associated with medicines and care plan audits had not identified inaccurate information. A medication audit did not identify medication recording and procedural errors.

There was a registered manager who had recently started work at the service from 30 June 2015. The registered manager had begun to identify some areas for

Summary of findings

improvement and development at the home, including changes to shift patterns and shift handover sessions. 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.

There was not enough suitable staff to keep people safe and meet their needs. People were not receiving the care they needed because staff had left or were absent due to sickness or holiday and new staff had not been replaced in sufficient time. People and their relatives told us that staffing levels were not consistently sufficient to keep people safe or meet their needs.

People were not protected from abuse because two staff did not recognise the signs of abuse and were unaware of the risks that some people's behaviour presented. People were at risk from physical and psychological harm from each other yet two staff accepted that this was usual behaviour.

There were inconsistencies in how risks to individuals were assessed and care plans did not always reflect people's current care and support needs. Risks relating to falls and poor balance had not been updated following changes to their needs.

Plans were discussed with staff, actions taken and changes were made in response to recent emergencies so that learning from these events improved safety.

Medicines were not being managed safely. Medicine charts for 12 people were found to have gaps, making it difficult to tell whether people had received their prescribed medicines on time.

In June 2015 a fire inspection by the fire service found that certain fire equipment and system checks had not taken place and fire drills and staff training was not adequate. However since the fire inspection findings, action was taken to resolve and address this.

People were cared for by staff that did not have up to date plans to develop their knowledge and skills. There were inconsistencies in staff's experience of recruitment, training, supervision and support. Staff reported mixed experiences which meant that some staff received regular support and training while others did not.

People told us that the food was 'excellent'. There was variety and choice of meals including fruit, nutritional snacks and refreshments throughout the day.

People were given support to maintain their health through regular contact with health professionals including dentists, occupational therapists and GPs.

Where people lacked mental capacity to make decisions for themselves they were assessed and staff were made aware of how to support people with their decisions. Staff explained that some people had best interest decisions made to help keep them safe.

On several occasions we saw staff from one unit carry out care that did not respect privacy or reflect dignity when supporting people with their meal and when checking someone's skin. Staff comforted people when they were distressed. They asked people questions to clarify and understand their concerns and promote their well-being

People and their relatives told us staff respected them, acknowledged their choices and called them by their preferred name.

Some people did not receive individual care and support in a personalised way to meet their needs. Arrangements to regularly assess, record and review people's care needs did not always take place. Care needs were not always reviewed and managed in a practical way to reflect changes.

Equipment and resources were made available to help people retain their independence. These included rim edged bowls and plate guards to help people manage their food and hand rails to support people when they moved about the home.

Written complaints had been investigated, explored and responded to, although some people and relatives told us that while their verbal concerns were acknowledged, these were not always fully addressed and resolved. Compliment letters sent by friends and relatives about people who had died or moved on expressed positive comments about peoples experiences.

While quality checks were used to measure, monitor and review the delivery of care not all checks identified gaps in care or changes that required redress. Emerging themes from quality checks were not picked up and follow up actions from these checks did not show how some gaps we identified were being addressed.

Summary of findings

Care records and other records including staff training plans were not robust and did not sufficiently reflect what was happening on a day to day basis.

Staff told us there had been a lack of clear leadership and management of the home until recently and this had led to confusion about roles and responsibilities and low staff morale. People and their relatives expressed concerns about the changes in management and how this had affected their care.

The recently appointed registered manager was aware of the responsibilities involved in delivering an effective and well-led service and had started to address some of the challenges.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe. Two staff did not keep people safe from harm because they did not recognise the signs of abuse and were unaware of the risks that some people's behaviour presented to others.

There were inconsistencies in how risks to individuals and at service level were being assessed.

There was not enough suitable staff to keep people safe and meet their needs. People were not receiving the care they needed because staff had left or were absent due to sickness or holiday and permanent staff had not been replaced in sufficient time.

Medicines were not being managed safely or effectively. There were gaps in people's Medicine Administration Charts and it was difficult to tell whether people had received their prescribed medicines on time. However, staff were assessed for their competency in managing and administering medicines and work continued on medicine management from an improvement plan.

Plans were discussed with staff and action was taken in response to recent emergencies so that learning from these events improved safety.

Is the service effective?

Requires improvement

The service was not effective. People were being cared for by staff that did not have up to date plans to develop their knowledge and skills. The provider did not have arrangements in place for monitoring and developing staff training. Staff gave mixed experiences of the support, supervision and appraisals they had received. Following the inspection we were sent a planning document showing how this would be addressed for the remainder of 2015 and the year ahead.

People were supported to have sufficient food and drink. A variety of meals and snacks were made available and people were given alternatives to food they did not like.

People were supported to maintain their health through regular contact with health professionals including dentists, occupational therapists and GPs.

Records documented assessments of people's mental capacity and staff were aware of how to support people when making decisions.

Is the service caring?

Requires improvement

The service was not caring. Three staff carried out care in a manner that did not always reflect dignity or respect.

Equipment was provided to help maintain people's independence.

Summary of findings

People were called by their preferred name. Staff asked them questions to clarify and understand their concerns and promote their well-being.

Is the service responsive?

Inadequate

The service was not responsive. Some people did not receive individual care and support in a timely and personalised way to meet their needs.

Arrangements to regularly assess, review and record people's care needs did not always take place. Care needs were not always reviewed in a practical way to reflect changes.

Where people had complained in writing these had been investigated and responded to.

Is the service well-led?

Requires improvement

The service was not well led, although new management was working with senior leaders to address changes to improve the service. While checks were used to monitor the delivery of care, some emerging themes were not picked up in relation to accidents.

Records were not robust and did not sufficiently reflect what was happening on a day to day basis.

Staff and management had recently begun to share and develop an understanding of the challenges, concerns, risks and achievements affecting the service.

Buxton House

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 unannounced inspection was completed by two inspectors and a pharmacy inspector and took place on the 18, 23 and 25 August and on 03 September 2015.

Before the inspection we reviewed information we held about the service including notifications, safeguarding concerns, accidents and changes the provider had informed the Care Quality Commission (CQC) about. A 'notification' is information that services have to provide to the Care Quality Commission about serious incidents and events and other changes to the service. We requested and received a Provider Information Return (PIR) from the service before the inspection. A PIR is a form that asks the provider to give key information about the service, what it does well and the improvements they plan to make. During the inspection we asked the provider to tell us what they did well and the improvements they planned to make.

We spoke with nine people living at the home and six relatives. We spoke with fifteen members of care, catering and laundry staff including the registered manager and senior staff, and three agency staff. We made contact with three social care professionals to seek their views and who provided support and services to people living at the home and who worked in partnership with the service.

We looked around the home and observed care in communal areas. We tracked the support people received and used the Short Observational Framework for Inspection (SOFI) at lunch time. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed five people's care records and risk assessments and 33 Medicine Administration Records (MAR) along with other documents related to the care people received. These included accident and incident records, complaints and compliments. We checked records relating to the running and management of the service such as health, safety and hygiene checks, a fire officer's report, environmental assessments, and records from staff and other meetings, and internal and external quality assurance checks.

Requires improvement

Is the service safe?

Our findings

There were insufficient numbers of suitable staff to keep people safe and meet their needs. Agency staff were used to fill gaps in the rota because of holidays, sickness and vacancies. The registered manager had started to recruit new staff to the service to provide improved continuity.

People told us that there was insufficient staff available most days to meet their needs. One person told us, "You sometimes have to wait after calling the emergency bell, I think they could do with more staff at night sometimes I wait a long time other times they are quick". Another person said, "There is a lack of staff, not enough, just agency. It affects what time I can get up and get to bed". One relative said, "I'm concerned about the staffing levels here and I have spoken to social services". Other people's relatives told us that they believed the lack of regular and appropriate staff had meant that their family member was spending more time alone and needed more help when taking their medicines but that staff were not available to provide this support.

Staff told us that the home had been understaffed for months. Comments from staff included, "Staff care, but there's just not been enough staff to give the full care people need". One staff member explained that on some days staff were short due to sickness and holiday but bank staff were not always contacted to cover in time. Staff explained they frequently had to re-prioritise, swap shifts or 'float' between units to cover. Another staff member said they had recently been left on their own to care for all of the people in one unit. Another comment included, "It's not safe when there is so few staff, and some people need support from two staff to move them when using the hoist, so people get left unsupervised on the unit, that can't be safe". A recent staff survey highlighted the lack of appropriate staff including comments such as 'There is too much reliance on agency staff'. The provider responded to the comments and acknowledged this noting the benefits of regular staff.

Records showed that across several months there were gaps in the rota which had to be filled by agency staff. Across eleven days in August 2015 a total of 89 agency staff were requested to cover gaps in the rota. Twelve staff from across care, domestic, catering and activities had left the organisation since 28 April 2015. Similar gaps were noted in the availability of staff on the cleaning rota across several months. Staff told us the domestic team had been understaffed and that only three domestic staff, and on occasions, only two, were available when four was the full compliment. In minutes recorded following a staff meeting odour in parts of the home had been noted and at the inspection there were two areas of the home where we experienced malodours.

We saw several people who spent the day in their wheelchairs. Two people told us they were never asked if they wanted to be seated elsewhere and one person said, "They haven't always got the time or staff to move people" and "Once I am in this chair, that's it, I don't move".

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

People were not protected from abuse. Staff did not keep people safe from harm because they did not recognise the signs of abuse and were unaware of the risks that some people presented to others.

While some staff told us about the signs of abuse and how they would record and report this, other staff did not identify the risks. Two staff were unaware of their discriminating views towards people who lacked capacity to protect themselves.

We saw that two people were at risk from physical and psychological harm. Both people became agitated and were verbally and physically aggressive towards each other on several occasions during a meal time. On one of these occasions two staff that were supporting people in the dining area, showed little concern that two people were behaving in a way that put each other at risk of physical harm. We spoke with two staff who did not understand that the behaviour of both people towards each other led to the risk of harm, injury and abuse. One staff member told us that verbal and physical disputes between these two people often happened, and this was "The norm". Another staff member told us that the two people had a "love, hate relationship". The staff member said, "They bicker a lot but make up."

We checked the care records of both people and found that a similar matter had been previously recorded in the notes for one of them but no risk assessment had been completed and the concern had not been escalated or

reported to senior staff or the local authority. There was no record of this behaviour in the second person's care plan or risk assessment. We informed the registered manager who explored the incident informally at the time with staff.

We raised a safeguarding alert following the incident and a safeguarding report was followed up and sent to the local authority by the registered manager. We contacted the statutory authority who closed the safeguarding investigation in September 2015 following discussion and guidance provided to the service and action taken by the provider.

People's property was not always protected. Several people including a relative had raised concerns about lost property, damaged laundry and finding clothes belonging to other people in their relative's room. On one occasion this had been noted as a written complaint. A staff member said, "We had a whole rail of lost property and the domestic team were understaffed". The registered manager was aware of the problems and had initiated a laundry recognition round although people were still experiencing lost and damaged garments.

One relative told us that they were concerned about their family member's welfare because they had been injured and had sustained cuts and bruising on several occasions following confrontation with other people living at the home. They felt this had affected the person's overall mental health and wellbeing. They told us that despite bringing this to the attention of staff, actions had not been taken to address the risk early enough and they had not been kept involved or informed in a timely way. We checked the records and found that an entry had been made in an accident record. Staff told us they had been asked to ensure this person was closely monitored following more recent incidents.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that one person had a pressure alarm mat to alert staff of when they were beginning to move around as they were at risk of falling. This person's alarm mat sounded continuously for several minutes without staff coming to attend. We called staff to attend because the person had moved close to their room door without the necessary equipment and supervisory support they needed and we were concerned for their safety. Agency staff were not always informed of people's risks. One agency staff told us that on their first shift they were not informed of who needed moving and handling support with the use of a hoist and had not been informed of the needs or risks to people at the home. They had not been told who at the home had diabetes. Another agency staff told us they had been requested to attend at very short notice and had not had time to learn about people's needs.

Actions had been taken to respond to a recent incident in one of the units. Several staff had left the unit briefly to attend to other responsibilities. This meant the communal area was left unsupervised which led to an incident between two people using the service. Plans were discussed with staff so that learning from these events improved safety. New arrangements had been made to ensure that care staff remained on the units at all times. Staff were aware of this decision and there had been no further recorded incidents.

Medicines were not being managed safely or effectively. There were gaps in people's Medicine Administration Records (MAR) and it was not possible to be sure if people always received their prescribed medicines. Medicine checks had been carried out but had not identified the gaps we found. Medicines were stored securely, however while some records were available to show that temperatures were monitored for one pharmacy refrigerator this was not the case for a newly purchased refrigerator.

Two relatives and a person living at the home gave accounts of recent unsafe management of medicines. One relative told us that their family member had missed medicine dosages and that tablets were found in their room. This meant there was a risk that they did not receive their medicine on time to treat their condition and they were at risk of taking an inaccurate or second dose before it was safe to do so. People could manage their own medicines once assessed as safe for them to do so. Staff explained the procedure for administering medicines and the actions taken for medicine errors, in line with the policy.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A staff member explained that the medicine cupboard remained locked and only senior staff held the keys. They told us that people were given their medicines one at a time in a medicine pot and remained with them until the

Requires improvement

Is the service safe?

medicine had been taken. Another staff member explained how medicine errors were addressed which included contacting the emergency services and the GP for advice, informing the person's family and the most senior staff member, and recording the incident.

In June 2015 a fire inspection found that certain fire equipment and checks had not taken place and fire drills and staff training was not adequate. We spoke with the fire and rescue service who confirmed this. Since the fire inspection findings fire procedures had been reviewed and appropriate checks and warning systems had been tested. Staff had also received training and information about what action to take in an emergency and records confirmed this. Five care records showed that people had Personal Emergency Evacuation Plans outlining how and where people could be safely evacuated to in the event of an emergency.

Staff had recently been recruited using appropriate employment procedures. Two newly recruited staff explained their experience of the recruitment process. They completed application forms, attended interviews and responded to questions about their care experience. Both staff told us they were asked to provide proof of identity, health and employment history, references and Disclosure and Barring Safeguarding clearance, otherwise known as the criminal records check. Three sets of records confirmed this.

Requires improvement

Is the service effective?

Our findings

When agency staff were requested to cover gaps in the rota, the agency provided Buxton House with information about these staff skills and experience. Information was sent to us following the inspection outlining these details.

There were inconsistencies in staff's experience of recruitment, training and support. One staff member who had been at the service for between six months and a year, told us they had limited experience when they joined and received no induction plan or introduction to the home or people living there. They told us they were left to learn without support, guidance and appropriate training. They gave examples of being left to manage the care of catheters and pressure wounds without appropriate training, guidance or support. The registered manager acknowledged there may have been previous inconsistencies in staff induction; training and development but that staff employed more recently received a robust induction process. This was confirmed by a recently recruited staff member who told us that they had watched other staff as part of their introduction to the home and confirmed their corporate and a care home induction. They said, "I've made progress and had informal and on-going supportive feedback". The registered manager explained how new staff were supported into their roles, which included starting their care certificates. Care certificates have replaced the social care induction programmes.

The provider had arrangements in place for monitoring and developing staff. Nevertheless staff gave mixed experiences of the support, supervision and appraisals they had received.

While some staff had received guidance and support through supervision meetings, others had worked at the service without the same level of support. One staff member said, "I've had one supervision session and a group supervision session since February 2015". Another staff member commented, "In the last year I've had no training apart from first aid and no supervision, support or appraisal since my probation". One staff member told us they received supervision more often although they worked different shifts to their supervisor which made it difficult to meet.

Records of staff supervision and appraisal suggested that while some had taken place; these were inconsistent which meant that not all staff received the support they needed on a regular basis. Following the inspection the provider sent a plan of how staff supervision and appraisal would be managed across the remaining year and through into 2016.

The training schedule was not up to date and there was a lack of clarity in what training staff had received and when. We saw an induction checklist which was used to link policy information to induction training. Some staff told us that they had relied on training they had received from previous employment because they hadn't had updates while at Buxton House. Training had been discussed at a recent team meeting and the manager explained that all new staff being recruited had received a robust induction followed by an on-going training plan. The manager also explained that for existing staff their training plans would be reviewed and updated as a matter of priority. This work had not started at the time of our inspection but we were told this was part of work in progress. People received care from staff that were not appropriately trained or supervised.

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

People's nutritional needs were identified and monitored and this included the recording of people's weight and assessment of their risk of malnutrition. Hospitality staff were well informed of people's dietary requirements and preferences. Risks to people with a variety of complex dietary and health needs were identified. Colour coded menu plans were used for those who required softened, thickened and easy to swallow food. These were detailed, having been requested by dieticians and a speech and language therapist. People with diabetes and those who required reduced or extra calories to help them lose or maintain their weight had menu plans to support these decisions. Where appropriate, extra food and refreshments were made available to people throughout the day besides the usual mid-morning and afternoon refreshments. Non-perishable food was stored in kitchens on each unit so that people who required extra calories or became hungry between meals could have snacks if the catering staff had finished their shift.

People felt the quality of the food was excellent and one relative said, "Good choice of food and regular drinks". People were supported to have a balanced diet. We saw

Is the service effective?

one staff member providing assistance to someone at lunch time who was unable to eat their meal unaided. People were involved in decisions about their food choices, for example, people were shown a choice of meals to make it easier for them to choose meals that visually appealed to them. Food was presented appetisingly and there was a varied menu. Catering staff explained that people had a choice and if they did not like the meals offered they could request an alternative. We saw plates and bowls designed to encourage and assist people to eat and maintain their independence. Examples included brightly coloured bowls to help people with dementia be more inclined to eat and recognise their food.

People were supported to maintain their health through regular contact with health professionals including dentists, occupational therapists and GPs. Staff told us about several people who needed support from opticians, hospital specialists and mental health teams including referral to psychiatrists and community psychiatric nurses. Several people had been referred to healthcare professionals who were visiting people while we were inspecting. Some people who had capacity told us they discussed their health needs with staff. One person told us about how the staff had arranged an eye test and took them to see the optician for new glasses.

Referrals were made to healthcare professionals when they required medical attention and treatment. One staff member told us about someone who required an urgent visit from a community nurse to assess their skin and to reduce the risk of a pressure wound. Another staff member gave an account of when someone needed to see their GP for treatment of a urine infection and who required antibiotics to prevent it worsening.

Some people living at Buxton House did not have the mental capacity to make decisions about their care and where they lived. The registered manager confirmed that they worked with the local authority to identify people where the arrangements for their care may deprive them of their liberty. Applications for Deprivation of Liberty Safeguards (DoLS) had been made and the registered manager was waiting for the local authority's response.

DoLS protect the rights of people living in care homes from being inappropriately deprived of their liberty. Checks are made to ensure that there are no alternative ways of supporting the person safely first without using a DoLS.

Records showed that people's mental capacity had been assessed and documented. The Mental Capacity Act 2005 (MCA) provides a legal framework to ensure that best interest decisions are made for people when they do not have capacity to make decision for themselves. Staff understood this principle and encouraged people to make choices for themselves where this was possible. One person who had dementia was shown a choice of two meals because they could not remember what they had ordered. Another person was asked how they wanted to spend their time. The staff member offered a choice of books or the option to join an activity taking place. In one record we noted that a 'best interest' decision had been made to provide a special injury prevention mat. This mat was used to reduce the risk of harm in the event of a fall from the bed and was considered the least restrictive action to monitor the person's wellbeing.

We saw that people were not restricted in their movements about their immediate environment and had the freedom to choose where they went.

Staff were aware of the Mental Capacity Act 2005 and how this affected people's care. They had received guidance and training about mental capacity but had not received training on the DoLS. One staff member said, "I've had training about MCA and if someone does not have capacity to make their own decisions, we discuss with senior staff and their family". They told us about two people who had a 'best interest' decision in place for the use of a pressure alarm mat used at night to help alert staff to their movements.

One staff member described a covert medicine 'best interest' decision made for someone and gave the reasons for why the decision was made. This decision was clearly documented in their mental capacity assessment, and discussions were recorded to show that this person's best interests had been taken into account. This showed staff understood how decisions in these cases were made.

Requires improvement

Is the service caring?

Our findings

While the majority of staff demonstrated dignity and respect for people, this was not everyone's experience. One person told us that when they needed the toilet they often had to wait. They said, "I shout for ages and wet myself, they are overworked". One person's privacy was not taken into account when delivering care. We saw that someone had a skin condition and several staff showed attentive support. However, the staff began to examine the person's legs in the communal lounge area of the home which meant that their leg was being raised and this was undignified. We also observed an agency staff member and another employed staff member giving support and assistance to two people with their meals. Throughout the 20 minutes we observed this activity neither staff made any attempt to communicate or involve the two people with their meal experience. The activity was carried out in silence with no interactions or engagement. The activity was carried out in silence with no interactions or engagement. This may have indicated that some people's social and psychological needs were not considered during these activities.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We observed one person being comforted by a senior staff member when they became distressed. Two people became tearful and restless and staff took practical measures to alleviate their distress, for example, staff sat with them to help them focus on their meal by describing the food. Two people were talking together but both became concerned because they were unsure of their environment and surroundings. We saw a staff member sit and talk with them about their lives before they came to the home. Staff were observed interacting and talking with people about their families and personal possessions that held meaning to them. We heard several staff explaining information about people's medicines to them and responding to questions about their care. Staff were heard encouraging people to be independent where this was possible. Staff explained information to people as they attended to their individual requests, showing an interest while addressing their needs.

People told us that staff were caring. One person said, "They'll do anything they can to help; it's just that there isn't enough of them". Another said, "The staff are helpful; I'm very happy with the carers" One person commented that they liked living at Buxton House. This person was well supported with their personal care and appearance. They told us that staff had styled their hair and painted their nails. Another person said, "A good atmosphere, they call me by my first name; I feel very happy here and feel at home".

One person's relative told us that staff were caring. They said, "Staff are compassionate; they always speak to us when we come in, they seem attentive and very kind". Another relative said, "The staff care and many of them are very kind and supportive, but there needs to be more of them, they do their best but they are so rushed". Relatives and people told us that visitors and family could visit without restrictions.

One staff member commented how plate guards had helped one person maintain their independence at meal times. Staff talked about people in a respectful and considerate way showing awareness of some of the problems and challenges that people experienced. They gave examples of how they had responded to individual requests and resolved people's concerns.

We spoke with the registered manager about the role of advocacy services for people at Buxton House, in particular for those who lacked capacity to make informed decisions because of their cognitive conditions. The registered manager told us that independent advocacy services were not currently used at Buxton House but this could be considered in the future as part of the home's service development plan.

Inadequate

Is the service responsive?

Our findings

Some people did not receive individual care and support in a timely and personalised way to meet their needs. One person was in their night clothes and had not had their hair brushed or teeth cleaned and were calling for help at 12:45pm after their lunch had been served. This had not been noted by staff until we drew this to their attention, by which time their food was cold and untouched. We spoke with staff about this person and were told that this was due to their personal choice. However this person lacked mental capacity and was upset and unable to orientate themselves to their surroundings, repeatedly calling out in a distressed state.

Some people's care had not been reviewed when changes had occurred and did not always reflect people's current care and support needs. For example, it was recognised that one person's risk of falling had increased in May 2015 but this had not been reviewed and addressed at the time, this was later amended in June 2015. This meant that for several weeks this person remained at risk before their care plan was fully updated.

A night care plan assessment stated that one person slept well at night but their daily notes recorded 'restless nights'. Risks in relation to one person's toileting choice and changes in their mental health had not been assessed or documented. For example, the person improvised with equipment, using a bowl to go to the toilet which put them at risk of losing their balance.

Two people's behaviour had changed and while their daily records showed that these changes had taken place, there was no up to date care plan detailing their behaviour or the risk to themselves and others. This meant that staff did not have a complete plan on how to support these people safely.

People and their relatives were involved in and contributed to their initial assessment prior to and in the early stages of living at the home. However, people's individual and changing needs were not always reviewed or recorded and this was confirmed by people and comments we read in minutes from meetings and monitoring checks. Initial assessments provided information about people's histories, including their personal interests. Several people told us they had been involved in the initial stages of their assessment. However, arrangements for people to have their individual needs regularly reviewed and recorded did not always happen. Someone told us that apart from their initial assessment before living at the home they did not feel fully involved or consulted in the care they received. One person said, "I was asked questions about my health before I came here but that was all, not much since". One person told us they would prefer more baths but this was not discussed and they were not given a choice as the decision was often made for them. Someone commented, "I'd like to get up earlier but I've never been asked and when I mention it nothing changes and there's no response". This person told us they had not seen their care plan. This showed that people were not regularly consulted about their choice of care.

People, relatives and several staff told us that people were left in bed for so long that they either missed meals or were receiving food as close as an hour between meal times. For some people meals were sometimes rushed and not appropriately spaced or flexible to meet their needs. Several people told us that it had taken so long to be washed and dressed that their lunch immediately followed their breakfast. People and their relatives also explained that the lack of staff affected the level of personal care people received and impacted on their individual choices. One person said, "By the time I'm up and had breakfast, they are already serving lunch". A relative commented, "I've seen lunch served less than an hour after breakfast". Someone else said, "I'm not hungry by lunchtime because breakfast has been so late". One person commented, "I like to get up between 07:30am and 11:30am but it depends on how many staff are on duty; sometimes it's lunch time before I'm up". This meant that for some people care was based on staff availability rather than their needs. Two people told us they had been left to fall asleep in their chairs, one said; I am often left to sleep in the chair till late. You wait so long at night for the bell to be answered" and "no point using call bells they are overworked".

A relative commented, "He needs more help but we find food everywhere; so he is not getting the support he needs". One relative told us their family member had lost weight while at Buxton House because the individual support wasn't readily available to meet the number of people who needed help.

One relative said, "I don't think all staff understand older people and their problems. It's easy for staff to walk by without realising. I often find a drink has been left

Is the service responsive?

untouched or tablets haven't been taken. People who cannot see or hear need more help". Another comment included, "Staff are not always aware of people when they have problems and what they need; they often get left so I come to help with food".

On one occasion, someone requested a medicine review from their GP. This was recorded in the diary but we found no evidence that this had taken place. No entries were found under professionals' visit notes; daily notes and the person's medicine chart for that period could not be found.

In the minutes of one team meeting in July 2015, reference was made for the need to improve person centred care and that some care plans did not reflect people's current needs and choices. In the minutes staff were made aware that care plans should be reviewed and recorded at the time people's needs changed rather than as an end of shift activity.

The registered manager acknowledged that the team and staff at all levels needed more support to deliver care that met with people's expectations. They explained that this would improve as staff became more aware of their roles. The registered manager told us that work was needed to support staff to re-engage with people and to understand that 'quality' and a 'person-centred approach' was at the heart of their work. In the minutes from a staff group meeting there was reference to a lack of choice reflected in people's care plans and assessments. We were told that staff were receiving additional guidance on care planning and during our inspection some staff were receiving support with this.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There were well developed links from within the local community. These included contacts with local schools, a college, and a choir group, a visiting community library and a garden project earlier in the year to design and create an outdoor space of interest for people to enjoy. We received numerous positive comments from people about this. Some staff and relatives told us that more stimulating activities could be provided for people who experienced dementia and those who had sensory impairment. One senior staff member told us that Buxton House had recently received support, guidance and advice from an organisation with an interest in promoting better practice and the provision of high quality activities for older people. A report had been made available and the leadership team were in the process of deciding how to implement the suggestions from the report findings.

Equipment and resources were made available to help people retain their independence. For example, plates and bowls had curved and rimmed edges to make eating independently more possible and there were hand rails to assist people's movement throughout the home environment.

People and relatives were listened to but some did not always have their verbal concerns satisfactorily addressed. We spoke with the relatives of three people who told us that recent and earlier concerns and complaints raised verbally about care were not fully addressed as they had expected. One relative said, "I lodged my concerns recently but I am still waiting to hear and that was several weeks ago".

Written complaints had been addressed. We looked at a log of concerns, complaints and compliments. Where people had written a complaint, their concerns had been reviewed, explored, investigated and responded to. The provider had a complaints policy and the written complaints had been addressed in accordance with the policy. Some complaints and incidents were used as a learning opportunity which helped to drive staff development and improvements to the service.

Cards and letters of compliments conveyed that relatives of some people had received a service which had met their expectations. One letter stated, '…treated with utmost care and respect'.

Most people said that although they could not recall having received specific written information about how to raise matters of concerns, they all felt that they could talk to senior staff and ask to speak with the registered manager. Some people told us that they raised issues relating to the home and improvements they wanted to see like staffing levels and how this affected their choices. These were discussed through group meetings they called 'resident's meetings' but people did not feel this yielded results. We asked people who had attended these meetings if they had seen changes. One person felt that little had been done to address the groups concerns. However, some points about food choice and activities had been addressed. We looked at an agenda and notes from one of these meetings but it

Inadequate

Is the service responsive?

was not clear how much progress had been made or followed up. We asked the registered manager and two staff about points discussed at these meetings and while many issues had been discussed by staff not all had been fully concluded and people who had raised these concerns had not received a recent update.

The registered manager was an experienced manager yet new to the home and had arranged meetings for residents and their relatives' to attend in July 2015, soon after taking up the post. The meeting was to inform people and their families of the recent changes to explain the registered manager's role and responsibilities and to encourage engagement and communication. One person told us they and their family went to the meeting and were encouraged to speak and raise any issues.

Requires improvement

Is the service well-led?

Our findings

Systems and processes had not been sufficiently and effectively established to ensure consistent and sustainable good governance at the home.

The provider did not identify some gaps when the service was monitored. Quality checks including nutrition, dignity and respect had recently been carried out but checks on accident reports had not been effective in identifying improvements. For example, accident patterns and incident trends had not been identified. We brought this to the attention of a member of the senior leadership team. The analysis from these checks was recorded as 'No trends noted'. In June there were 21 incidents and five accidents. In one report for May and June 2015 seven people were found on the floor following non witnessed incidents.

Internal monitoring checks on care plans found a number of omissions in records. While these were identified and highlighted there was no consistent information showing how these monitoring checks would be followed up or what actions would be taken. This meant that there was a missed opportunity for service development and improvements because monitoring findings were not checked and followed up.

Records did not sufficiently reflect what was happening on a day to day basis. One person's record showed they had fallen and had been seen by the paramedic emergency service. Details to be passed on included informing the GP the following day but there was no record documented in the diary for this and a staff handover note included details of the fall but nothing about informing the GP. Team meeting minutes confirmed that improvements were needed in managing records. This meant that staff were not being kept informed of the relevant changes to the care people needed and important information was not being communicated or passed on.

In one person's records dated September 2014 it was noted that the person did not display behaviours considered to be challenging towards others. However, this person had experienced challenging behaviour and the record had not been updated. Quality checks in June 2015 identified that several records required updating and completing. One included a moving and handling risk assessment that was incomplete and a review of someone's thinking and decision making skills. These were later addressed.

Whilst medicine checks had on occasions identified errors and omissions, work was being carried out to reduce the occurrence of gaps found when administering medicines and the impact on people. Staff were assessed to check their level of competency in managing and administering medicines. We were sent details about the plans the provider had made to address this work and a further plan was sent following the inspection.

Buxton House had not had consistent management support. The senior leadership team which included operational management roles had not been visible at the service until recently. This was confirmed by staff. We were told there had been numerous changes to leadership and area management posts. Several posts had become vacant and the home had therefore not received regular or consistent management support. This meant that at a senior leadership level there had not been consistent management support and guidance available to staff at the home and this was confirmed by staff. We were told by the registered manager that this was being addressed and changes to senior roles were expected.

One staff member said, "There has been a lot of turnover of managers and senior staff, only recently have we seen more involvement from senior managers; it has affected morale". Some staff expressed their 'hope' for more positive change and greater stability while some staff told us there had been such a lack of management and leadership stability this had resulted in care staff leaving and low morale. Comments included, "Morale is low due to constant change and re-structuring, Buxton House had lost its way" and "The management structure is fractured which doesn't install confidence caused by instability". Staff described a lack of effective management over many months, resulting in their roles and responsibilities becoming unclear. This made it difficult for staff to make decisions and take the appropriate actions. One example related to laundry care. People, relatives and staff told us that people's laundry frequently went missing and caused concern for people yet this had not been adequately resolved for many months but more recently was being reviewed.

People told us there had been lots of changes in management which made it difficult for them to know who took overall responsibility. Comments from people included, "Well, there have been different people in charge, this keeps changing, you don't know who the boss is" and

Requires improvement

Is the service well-led?

"It gets very confusing, but the new lady needs time of course". One relative told us, "Previous senior management were never here at weekends, you never saw them, I'm not sure that's changed yet."

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

The newly appointed registered manager was aware of these and other concerns and was holding meetings to address the problems and provided examples of how the service was intending to improve. The staff and management had recently begun to share and develop an understanding of the challenges, risks and achievements affecting the service. Staff told us about a number of team meetings that had taken place for different staff groups including a 'senior's' and a 'care staff' meeting to discuss and exchange information. A recent management meeting had taken place, where staff of all grades was invited to discuss the strengths and challenges for the service and to identify where improvements were needed. The meeting was inclusive and staff were invited to make contributions and where problems were identified solutions 'should be proposed'. This was confirmed by several staff. We were shown minutes from this meeting which outlined the current concerns within the service and how these would be addressed through improvement priorities, besides details of what was working well. One worker told us that the staff had not been working as a team but things were gradually improving.

The registered manager explained that discussions about a proposed rota had taken place with senior management to ensure that day staff were available to offer extended day time support. While this was not in place at the time of the inspection it was planned for implementation following full staff consultation.

The newly appointed registered manager and the leadership team were transparent and open about shortfalls in the service. Operational concerns including how the service had not been meeting people's needs was being managed through staff meetings to address the problems. One example included plans and discussions for ensuring that only staff with key skills in supporting people with dementia should work on the units where people had dementia. This had not been addressed at the time of the inspection but other developments including changes to how staff provided information to each other at shift changes had been implemented, with good effect.

We met three senior leaders and the registered manager. They were providing support and on-going guidance to care staff and the registered manager. The newly appointed registered manager understood the responsibilities involved in delivering an effective and well-led service. They spoke about a request they had made for more service support from the finance, human resources and information technology department but acknowledged that whole service changes would take time to implement. One example was that several care staff had been encouraged and developed to take on specific roles including fire safety and buddy responsibilities. During discussions it was explained by the registered manager that this was work in progress and would improve as staff became more aware of their roles.

The registered manager told us the service had a whistle blowing policy and staff were encouraged to speak with the registered manager directly about their concerns and ideas for improvement and suggestions. One staff member said, "There is a whistle blowing policy and the new manager is holding meetings and getting staff more involved with improvements".

The registered manager and two senior staff told us about the company's key values at the home. These were known as the HEART values. This included honesty, excellence, approach respect and teamwork. While not all staff were familiar and aware of these values, the induction training introduced staff to these values.

There was a written service development plan in place which included weekly contact and monthly progress reviews supported by the registered manager and the senior leadership team. The service action plan was also openly discussed at a team meeting to engage staff fully in the process of planned developments and we were given a copy of the most up to date action plan.

The action plan gave indicators on how progress had been made at the service on specific areas of development. The action plan covered topics including records and administration, leadership and management, finance, staffing, quality assurance and dementia care. We saw two recent updates of this plan both dated in August 2015. However progress across the range of topics was considerably variable. For example, 10% of monthly care plan audits had a score of 0% and measuring tools for nutrition and pressure ulcer prevention and the management of Mental Capacity Act, Deprivation of Liberty

Requires improvement

Is the service well-led?

Safeguards checks scored at 0% and both these areas of care completion dates were due to be complete in September and August 2015 respectively. However, other aspects of care like contact with community professionals for pressure care advice and the re-issuing of policies to staff had scored 100%.

This showed that while some areas were showing good progress other aspects of people's care required further attention. Following the inspection we were sent further plans by the provider outlining developments across the service with completion dates spanning from September 2015 to May 2016.

Three staff told us that the new registered manager seemed fair and they could discuss problems openly. One said, "The new manager is firm, fair and lovely to work for, I received positive praise and helpful feedback recently; there's a good team feeling now" and "It's been unsettled with lots of managers but I feel positive about this one". One person said, "There's a new manager here and things have got better since she started".

People had been involved in developing and improving the service through meetings, national surveys and group discussions. Some people told us that meetings took place where they could discuss their ideas and suggest improvements. Two people who had attended these meetings told us that some changes had happened but both people felt that the group's concerns like staffing had not been addressed. One person said, "These resident meetings are useful but we haven't had any recently and we haven't seen the staff member who organised them". The registered manager gave examples of some changes that had taken place as a result of these and other meetings. Changes included food choice and greater choice of snacks and the continuation of the candy shop. The housekeeping rota had been changed and staggered across both the am and pm shifts to improve the laundry service.

In 2014 the home had been involved in a national survey which involved people living at the home This was called Your Care Ratings 2014 survey and the home scored 828 points out of a total of 1000. This was a survey that involved people at the home completing national questions about different aspects of their experience of living at Buxton House. There had been no recent surveys or feedback questionnaires during 2015 or since the national survey of 2014.

Registration requirements including notifications were received by the CQC in line with the appropriate processes.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 People who use the services were not protected against the risks of abuse and improper treatment because staff were unaware of their responsibilities to protect people from harm. Regulation 13(1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not treated with dignity and respect. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have sufficient systems and processes in place to assess, monitor and operate a safe and effective service. Regulation 17(1)(2)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not receive care and treatment that was appropriate and met their needs. Regulation 9 (1)(a)(b)(c)(3)(a)(b)((f)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users and medicines were not managed appropriately. Regulation 12 (1)(2)(a)(b)(g).
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not protected against poor care and treatment because there was not sufficient numbers of suitably skilled and experienced staff deployed. Regulation 18(1)(2)(a).