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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Buxton House is a residential care home providing personal care to up to 61 people. The service provides support to older people including people living with dementia. At the time of our inspection there were 59 people using the service.

People's experience of using this service and what we found
Some people could not be consistently confident that the risks they faced would be assessed, managed and monitored and the care they needed would be provided.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; in the main, the policies and systems in the service supported this practice. However, some people's legal representatives were not always making decisions for people and best interest decisions were not always reviewed or updated following changes.

There were continued shortfalls in the record keeping, communication and governance systems at the service. Feedback from the local authority quality and safeguarding was not included in improvement plans. Notifications about significant events had not always been made. The governance systems in place had not fully identified all of our findings at this inspection.

Risks relating to infection prevention and control (IPC), including in relation to the COVID-19 pandemic were assessed and managed. Overall, staff followed recommended IPC practices with some minor areas for improvement. Safe visiting was supported.

The registered provider and manager took actions in response to our feedback and findings. However, we cannot yet be confident that this will impact positively on people living at the service.

People felt safe and were comfortable and relaxed with staff who supported them. Relatives told us they felt their family members were safe and overall were well cared for. Throughout the inspection we saw relaxed, kind and caring interactions between staff and people.

There were enough staff to meet people's needs and there was a core staff team who knew people well. Staff spoke fondly and knowledgeably about the people they cared for.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 November 2021).

At our last inspection we found breaches of the regulations in relation to risk management and governance. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve.

At this inspection, we found the provider remained in breach of regulations.

Why we inspected
We carried out this inspection to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have found breaches in relation to the assessing, monitoring and management of risks to people, involving people and/or their appointed representatives in decision making and people's care plans were not consistently updated. There were also shortfalls in relation to record keeping, making notifications and the governance of the service at this inspection.

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

We have issued warning notices for the breaches of regulation 12, Safe care and treatment and regulation 17, Good Governance. The provider must become compliant with the regulations by 8 August 2022.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Buxton House

Detailed findings

Background to this inspection

Inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and a medicines inspector.

Service and service type
Buxton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, this included notifications made by the service and concerns raised with the Care Quality Commission. We sought

feedback from the local authority and health professionals who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
Inspection activity started on 6 April 2022 and ended on 19 April 2022. We visited the service on 6 April 2022.

We spoke with four people who used the service to ask about their experience of the care provided and with four visiting relatives. We spoke with nine members of staff including the operations manager, registered manager, deputy manager, senior care workers and care workers. As most people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included elements of seven people's care plans and care records and Deprivation of Liberty Safeguards authorisations. We looked at a variety of records relating to the management of the service.

We also held a remote video call with the registered manager to discuss the governance arrangements at the service and to give inspection feedback to the operations manager and deputy manager.

After the inspection visit
We continued to seek clarification from the provider to validate evidence found. We looked at further records related to seven people in relation to medicines and risk management and daily care records. we also looked at records in related to oversight.

We asked the provider to share a poster asking staff and family and friends to contribute to our inspection. We received an anonymous concern which we asked the provider to investigate. We received feedback via our website until 29 April 2022.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection we found the provider had not consistently managed risks for people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulation 12.

Assessing risk, safety monitoring and management

- Some people's risk management plans were not consistently followed or accurate. This placed them at potential risk of harm or injury. For example, one person, who was at high risk of skin damage, had a plan in place that they needed to be repositioned every three hours. However, records showed the person was not repositioned or provided with any continence care for five hours. Another person's risk management plan included incorrect information about the consistency of their modified fluids, and they were not given the drink from the cup detailed in their Speech and Language Therapy (SALT) plan. A third person was given fluids of the incorrect consistency and there was conflicting information in their care plan and on the prescribed drink thickener's label.
- Some people's care and support records were not accurate. For example, one person's records showed that the person had eaten in the dining room, but they were in their bedroom. Another person's repositioning records did not reflect the position they were in their bed. These people were living with dementia and could not tell us their experiences. This meant these records could not consistently be used to monitor whether people were getting the care and support they needed.
- Emergency information for the fire service had not been updated to include the names of new admissions into the home and their personal emergency evacuation plans (PEEPs). The deputy manager took immediate action to update the emergency information.

The shortfalls in assessing, monitoring and management of risks were a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There had been improvements in the management of environmental risks since the last inspection. For example, sluices were locked. Other environmental risks were well managed and there was regular oversight of maintenance issues.

Using medicines safely

- Medicines were not always safely managed.
- People had care plans and risk assessments for their medicines. However, there was one person who was

having oxygen who had no risk assessment or management plan for this. This meant there was not information for staff on the safe storage and use of oxygen for this person.
● Topical creams and other external items, such as lotions were recorded on an electronic system. We saw there were details on how products should be applied and body maps to guide staff. However, on some occasions, it was only recorded as 'cream applied' rather than details of the specific product.
● There were suitable systems for ordering, storage and disposal of medicines. Temperatures were monitored to make sure medicines were kept correctly, including those needing cold storage. However, the full maximum and minimum range was not recorded which would provide extra assurance that the medicines were always kept at suitable temperatures.
● Medicines policies were in place to guide staff, and any errors or incidents were recorded, and investigated to try to prevent them happening again. Regular medicines audits were completed, and some areas for improvement were identified and action plans put in place. However not all the areas for improvement we identified during the inspection had been picked up by these audits.

The shortfalls in medicines management were a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recorded when medicines were given using an electronic system. These records showed that people received their medicines in the way prescribed for them.
● People could look after their own medicines if it was assessed as safe for them to do this. Other people were given their medicines by trained staff who had been checked to make sure they administered medicines safely
● When people were prescribed medicines 'when required' such as sedative medicines, there were person centred plans in place to make sure they were given when appropriate.

Learning lessons when things go wrong
● Accidents and incidents were recorded and investigated and where appropriate, measures were put in place to mitigate the risk of reoccurrence. Lessons learned were shared with staff at handovers, meetings and supervisions. However, recommendations from safeguarding investigations and local authority contract monitoring visits were not routinely shared with staff to make sure actions were taken and lessons were learnt.

Preventing and controlling infection including the cleanliness of premises
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were some bedrooms without the facilities for staff to safely remove their PPE and records of cleaning for two of the bathrooms had not been fully completed. Staff were not always observing when people needed support to manage their environment and hygiene. For example, one person had faeces on their walking frame, and we needed to point this out to staff. The registered manager told us they had taken action to address these shortfalls. However, we have not yet been able to test the impact of this.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider was facilitating visits for people living in the home in accordance with the current guidance. Essential visitors had been identified for people and confirmed they had continued to visit their family member at the home at all times.

Systems and processes to safeguard people from the risk from abuse

● People who could communicate their views with words told us they felt safe.

● Many people living in the home no longer used words as their reliable communication due to the progression of their dementia. We observed people were relaxed with staff throughout the home.

● Staff had received training in safeguarding and told us they understood their responsibilities.

● The registered manager worked co-operatively with the local authority safeguarding teams.

Staffing and recruitment

● The weeks prior to the inspection there had been a high reliance on agency staff. This was because of the impact of staff absences due to the pandemic.

● Additional staff had been recruited since the last inspection and staffing levels had also increased. Staff, people and relatives told us there were enough staff to meet people's needs. One person said, "When you call them [staff] they come. There are enough staff."

● There was a core of staff who had worked at the home for a number of years and they knew people well. Staff told us they felt there was a good mix of new and experienced staff working.

● People were supported by staff who had been safely recruited. Staff recruitment records showed pre-employment checks were carried out before staff joined the service, including checks to ensure staff were suitable to care for vulnerable people.

● This included Disclosure and Barring Service (DBS) checks that provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● The provider had continued to make bonus payments to new and existing staff to welcome them to the organisation and to thank them for their hard work and commitment during this challenging time.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the last inspection we recommended the provider review how they ensured they had sought the decisions of people's legal representatives in line with national guidance.

- At this inspection where people lacked capacity, mental capacity assessments were undertaken. People's legal representatives, relatives and professionals were consulted and involved in best interest decisions.
- Where people had appointed a legal representative to make decisions about their health and welfare, it was still not clear that these representatives had made decisions rather than be consulted. The registered manager told us they had involved and recorded the decisions of people's legal representatives for any new admissions into the home. However, they had not yet done this for the people who were living at the home at the time of the last inspection.
- One person having their medicines given covertly (in food or drink without their knowledge or consent) had mental capacity assessments and 'best interest' decisions recorded. They had details of how the medicines should be given, however, this had not been updated since there had been a change in their prescribed medicines.

The shortfalls in working within the principles of the MCA were a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Before people moved into or stayed at the home, their needs were assessed. From these assessments care plans were developed.
● Overall people's care plans reflected people's needs. However, there were elements of some people's care plans that were not updated or guidance followed when their needs changed. For example, one person was seen by the district nurse for a pressure area on their heel. The district nurse gave guidance and repositioning recommendations. However, the person's care plan was not updated to reflect the change in frequency of repositioning, and a wound progress chart was not completed as detailed in the care plan. This meant staff did not have a clear plan to follow and reposition the person as required to minimise further skin damage.

The shortfalls in updating people's care plans was a breach of breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Mealtime experiences were mixed with some good practice and interactions between staff and people. There were relaxed and varied atmospheres in dining areas with staff chatting with people whilst they supported them to eat and drink. However, some people had inconsistent support from staff and there was no consideration for whether meals were hot after long periods of time for those people staff supported with eating and drinking.

The shortfalls providing people with a personalised care and support was a breach of breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's weight was monitored. The staff liaised with health professionals if they identified people were losing weight or struggling to eat and drink safely.
● People were happy with the meals and snacks provided. Since the last inspection menus were displayed in large print. Since the last inspection, people were being offered both visual and verbal choices of meals.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's oral health care was assessed and planned for. However, as identified at the last inspection the recording of oral care was not robust and it was not possible to use the records to determine the support people had received to maintain their oral health. For example, one person's records only included oral care being provided nine times in seven days.
● The home had a named clinical lead from the primary care network. The home was visited regularly by named professionals and this ensured people received consistent support to meet their healthcare needs. One healthcare professional told us they had improved confidence in the staff making timely healthcare referrals. This was following the healthcare professional working closely with the registered manager and staff team to make improvements.

Staff support, training, skills and experience
● Some core training had not yet been completed for some staff and this was included as an action in the service's improvement plan and they anticipated completion of all training by May 2022. This was an area for improvement.

● People had confidence in the skills and knowledge of staff. One person said, "Staff have the skills they know what they are doing."
● Staff had completed induction training and on-going training was planned.
● Staff had support that enabled them to carry out their roles. Staff felt well supported by the management team and told us they had regular supervision or support sessions. A staff member said, "100% I feel so supported. There is always someone about."

Adapting service, design, decoration to meet people's needs
● People's bedroom doors had their names, and in some cases other identifying pictures, on. This helped people to find their own rooms.
● People's bedrooms were personalised with photos, pictures and belongings that mattered to them and reflected their tastes.
● Communal areas provided a variety of seating options for people to choose who they spent time with. The rooms were bright, and furniture was laid out in ways that supported interaction between people. Furniture had been replaced since the last inspection. A café area had been created to support people to socialise with each other and with family and friends. People and their relatives were using this during the inspection.
● There were plans in place to further develop the environment to make it more dementia friendly. There was not any timescale for this planned work.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to Inadequate.

This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found the provider did not have effective governance systems in place and there were shortfalls in record keeping. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulation 17.

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

- Although the provider had audits and some risk assessments and management and improvement plans in place, they were not effective and had not identified issues we highlighted at this inspection.
- Record keeping was not accurate and did not consistently reflect the care and support provided to people. The service had introduced an electronic care planning and recording system at the start of April 2022. Staff were being reminded about accurate recording at handovers. However, there was not any effective system for the oversight of people's records to ensure they were getting the care and support they had been assessed as needing.
- Handover records did not include changes in some people's needs and care plans were not updated to reflect guidance. People did not always receive personalised care and support.
- The registered manager told us the management and senior team were undertaking daily spot checks of the care, support, food and fluids people were having and the accuracy of care records. However, these daily checks were not recorded anywhere so it is unclear how any findings were acted on.
- Audits and subsequent action plans had not consistently resulted in changes to practices. For example, a mealtime audit completed in January 2022 identified that people were not always getting hot meals.
- The electronic governance system produced an overall improvement plan with timescales. The improvement plan also included actions from CQC inspections. However, the findings of all audits, local authority or safeguarding visits were not included in the improvement plans. It was not clear how these findings were acted on or shared with staff.

The governance systems had not effectively mitigated the risks to people using the service. The systems had also not identified all the shortfalls we identified at this inspection. This placed people at risk of harm or injury. This was a continued breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had not made sure we received notifications about all important events so we could check appropriate action had been taken.

The shortfall in making all notifications was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There were mixed views as to whether people and relatives felt the communication systems were fully effective. Some people and relatives told us they were kept well informed. However, this was not consistent. For example, one person said they had not been informed that the latest COVID-19 outbreak had finished and that the home was fully open to visitors. A relative told us they had not been informed that the home was closed to all, but essential visitors and they had travelled a significant distance. Another relative told us they had not been kept informed and updated about an injury to their family member. The registered manager told us that a new administrator had been appointed and they anticipated that communication would improve. Communication with people and relatives was an area for improvement.

● There were mixed views from relatives about the home. Comments from relatives included; "I can't speak highly enough. They're professional and we always get the sense they know her well", "So lovely here, when my time comes I'm booking myself in", and "It's been really difficult [pandemic] would like to have regular updates…have had to chase answers…and [registered manager] didn't email back."

● There were monthly themed surveys completed with people living at the home. The registered manager told us improvements had been made a result of feedback from people and relatives. For example, menus were now produced in large print and people were offered a choice of two plates of food at mealtimes.

● Overall, people spoke positively about their experiences of the home. One person said, "It is easy to live here. If you want to do something you do it." Another person said, "It's like being at home only I don't have to do the work." A third person said, "I've never been unhappy, they would do something about it."

● People lived in a home where there was an ethos of providing personalised care. There was a core of staff who knew people well and they spoke positively and fondly about the people they cared for.

● The registered manager and staff we spoke with told us there was improved teamwork and morale, particularly following a recent COVID-19 outbreak at the home. Staff were proud of the teamwork and showed they genuinely cared for people living at Buxton House.

● Staff told us they felt valued and appreciated by the registered manager and provider. They felt their work during the pandemic had been recognised and they were well supported.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and provider understood their responsibilities to be open, honest and apologise if things went wrong. However, this understanding did not translate into effective communication between the registered manager and some relatives.

Continuous learning and improving care

● The registered manager told us they had learnt through feedback from the local authority and healthcare practitioners that they needed to understand local practices and protocols. This has resulted in better communication and more timely health referrals for people.

Working in partnership with others

● We received feedback from the local authority safeguarding and quality monitoring teams in relation to

their recent visits. Not all the shortfalls identified during their contacts with the service had been addressed. However, they reported an improving picture and better communication with the service. This was supported by the feedback we received from a healthcare professional.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications had not been submitted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not consistently updated and followed to ensure people received the care and support they needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There were shortfalls in the involvement and ensuring health and welfare decisions are made by legal representatives not staff at the home. Best interest decisions were not consistently updated following any changes.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The shortfalls in assessing, monitoring and management of risks and medicines management were a continued breach

The enforcement action we took:

We served a warning notice and the provider was to be compliant with the regulation by 8 August 2022.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems had not effectively mitigated the risks to people using the service. The systems had also not identified all of the shortfalls we identified at this inspection. This placed people at risk of harm or injury. This was a continued breach of regulation 17.

The enforcement action we took:

We served a warning notice and the provider was to be compliant with the regulation by 8 August 2022.