

Banbury Heights Ltd

# Banbury Heights Nursing Home

## Inspection report

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Banbury  
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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Banbury Heights Nursing Home is a residential care home providing personal and nursing care to up to 58 people. The service provides support to older and younger people with dementia, physical disabilities, sensory impairments, mental health needs, learning disabilities or autism in one adapted building, over 3 floors. At the time of our inspection there were 47 people using the service.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

### People's experience of using this service and what we found

#### Right Support:

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff did not always have the information required to provide safe, effective care. Care plans and risk assessments did not always contain relevant, up to date information within them.

People were supported safely with medicines. We found improvements had been made to medicines management.

People were supported by staff who had been safely recruited. The provider completed police checks and gained references for staff prior to them starting work. Staff received an induction and training.

#### Right Care:

Risks to people had not always been mitigated. We found concerns with risk associated with skin pressure damage, health conditions and supporting people with distress or anxieties.

Unexplained bruising had not been investigated or mitigating strategies implemented to prevent the risk of reoccurrence.

Staff had received appropriate training to understand people's individual needs and to follow the providers policies and procedures.

#### Right Culture:

Systems and processes were not always effective in ensuring the registered manager and provider had

oversight of the service.

Systems were in place to gain feedback from people, relatives, and staff. Staff told us they felt supported within their roles and people told us they felt safe.

The registered manager and provider were open and transparent throughout the inspection. Updated records and new procedures were implemented immediately after the inspection. However, these will require time to become embedded into practice to reduce risks.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection and update

The last rating for this service was requires improvement (published 14 May 2022) and there were breaches of regulation.

The provider completed an action plan after the last inspection to show 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 received concerns in relation to safety and oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has not changed from requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Banbury Heights Nursing Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement and Recommendations

We have identified breaches in relation to risk management and management oversight 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.

#### Follow up

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 well-led?**

The service was not always well led.

Details are in our well led findings below.

**Requires Improvement** ●

# Banbury Heights Nursing Home

## **Detailed findings**

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (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 completed by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

#### Service and service type

Banbury Heights Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Banbury Heights Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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. We reviewed the information and feedback provided to us by the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

#### During the inspection

We spoke with 10 people who used the service and 5 relatives about their experience of the care provided. We spoke with 10 members of staff including, the registered manager, deputy manager, nominated individual, operations manager, director, maintenance staff, nurses, and care workers.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

# 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.

Using medicines safely; assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure medicines were managed safely to protect people from risks associated with medicines. This was a breach of Regulation 12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12. Concerns with medicines management had been met. However, we found failings around risk mitigation. Therefore, the provider remains in breach regulation 12.

- People were at risk of skin pressure damage. Records did not evidence people were supported with repositioning within the specified timeframes to reduce the risk of skin pressure damage. Support with repositioning was not always recorded. For example, records for 2 people who required support to reposition themselves every 2 hours to reduce the risk of pressure damage evidenced gaps of 8 hours or more.
- People were at risk of potential abuse. When a person had an unexplained bruise, the provider had not completed any investigations to identify the potential cause and to put mitigating factors in to reduce the risk of reoccurrence.
- People were at risk of harm. Staff did not always record the strategies used to support people when they experienced anxiety or distress. Records stated at times up to 3 staff were involved in supporting a person in distress. However, there were no records to evidence who the staff were or what strategies staff used to de-escalate the situation or redirect the person. This put people at risk of inappropriate physical interventions.
- Staff did not always have the information required to support people safely. Not all care plans and risk assessments held up to date, factual information. For example, we found one person had conflicting information regarding their food consistency to reduce the risk of choking. Another person had no information regarding the signs and symptoms staff needed to be aware of regarding their health diagnosis.
- Information recorded regarding accidents and incidents did not always include the information required to ensure analysis of the information was effective to learn lessons and monitor trends or patterns.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At our last inspection we found medicine management required improving. We found concerns with the administration, storage and recording of medicines. At this inspection medicines were managed safely.
- The provider had policies and procedures in place regarding safeguarding people. Staff received safeguarding training.
- People and relatives told us they felt safe at Banbury Height Nursing Home. We were told staff were 'kind, knowledgeable and had a good rapport with people.'

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- The registered manager referred people to be assessed under DoLS. Any conditions related to DoLS authorisations were being met.

#### Staffing and recruitment

- People, relatives, and staff told us they felt there were sufficient staff to meet people's needs. One relative said, "I am sure there is enough staff on each shift as I have visited at various times of day and there has always been a member of staff available if I need to ask them anything."
- The provider used a dependency tool to identify how many staff were required on each shift. The tool used identified sufficient staffing was in place.
- Staff were recruited safely. The provider completed pre-employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

#### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- 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 responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- 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 followed government COVID-19 guidance on care home visiting.



# 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 remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure there were effective governance and quality assurance measures in place. This was a breach of regulation 17 (1) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- At the last inspection we found systems to monitor people's daily care delivery were not developed enough to support the manager to check whether people had received their personal care as agreed. During this inspection we found systems and processes were still not in place or embedded into practice to ensure people received safe, person-centred care.
- Systems and processes were not effective in identifying when care had not been delivered in line with people's assessed needs. For example, we found concerns with the recording of support offered to people with repositioning, and with the recording of fortified food and snacks to reduce weight loss concerns. This put people at risk of neglect and harm.
- Systems and processes were ineffective in identifying when a person sustained an injury that required an investigation. Unexplained bruising had not been investigated to identify a potential cause; therefore, trends and patterns could not be identified.
- Systems and processes to audit or review people's care files were not effective in identifying when information was missing or conflicting within care plans and risk assessments. This meant staff did not have the information required to support people safely.
- Systems and processes had not identified when mental capacity assessments and best interest decisions were not completed. Mental capacity assessments had not been completed for each decision required. For example, mental capacity assessments had not specifically been completed for personal care, medication, equipment, sharing information or when people were sharing a bedroom.
- Systems and processes to identify any trends or patterns for incidents or accidents were not effective. Audits were not completed on records of people's agitation or anxiety. We found concerns with the documentation of how staff responded and what actions were taken to mitigate the risk of harm for people

who experience episodes of distress or anxiety. Therefore, trends and patterns could not be assessed.

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (1) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to submit the required statutory notifications. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- The registered manager was aware of their duty of candour responsibility and had systems in place to ensure compliance.
- Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The provider had systems in place to take account of staff, relatives, and people's opinions of the service. The provider requested feedback from people, relatives, and staff annually through a survey and then implemented an action plan to make improvements.
- Staff and people were offered regular meetings to share information about the service and discuss any issues.
- Care plans were completed with people or their relatives as appropriate.
- Relatives told us the staff kept them up to date on any changes, incidents or accidents relating to their loved one. One relative told us, "The staff always contact me with any updates regarding [person's] health or care needs."

Working in partnership with others

- The provider implemented new systems to improve the oversight of the service after the inspection. However, these need to be embedded into practice and sustained.
- The provider and registered manager were open and transparent throughout the inspection.
- The provider and registered manager worked in partnership with other health and social care professionals.

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
Diagnostic and screening procedures	The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks.
Treatment of disease, disorder or injury	

**The enforcement action we took:**

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.
Treatment of disease, disorder or injury	

**The enforcement action we took:**

Warning Notice