Care South

Buxton House

Inspection report

423B Radipole Lane
Weymouth
Dorset
DT4 0QJ

Tel: 01305760834
Website: www.care-south.co.uk

Date of inspection visit:
21 November 2017

Date of publication:
28 December 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook an unannounced inspection of Buxton House on 21 November 2017. When the service was last inspected in June 2016 no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, at the last inspection we found that improvements could be made in relation to risk management, the submission of Deprivation of Liberty (DoLS) applications and the overall quality monitoring and governance. During this inspection we found that improvements had been made.

Buxton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is able to accommodate up to 64 people. At the time of the inspection there were 64 people living at the service.

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

People at the service told us they felt safe and that staff supported them well. People's relatives also spoke positively. There were systems in operation to ensure that safeguarding concerns were identified and responded to timely. People's risks were assessed and managed safely, and where risk management plans were in place we saw evidence this had been done in the least restrictive way. There was learning from adverse incidents such as accidents and falls. The premises and equipment was maintained to ensure it was safe. We received some mixed feedback on staffing and have made a recommendation on increasing the frequency of reviewing the staffing dependency tool. Recruitment was safe and people received their medicines when they needed them from competent staff. The service was clean.

People's physical, mental and social needs were assessed. Nationally recognised tools for the identification of skin damage or weight change were used to achieve positive outcomes. People said they received effective care from staff. Staff had received appropriate training to meet the needs of the people they supported. New staff received an induction aligned with national accreditation and there was an ongoing programme of supervision and appraisal. People received support to eat and drink sufficient amounts.

Staff worked together to communicate people's needs and people were supported moving between services. No concerns were raised by people or their relatives in relation the adaptation or design of the service. Staff understood their obligations under the Mental Capacity Act 2005 and we saw capacity assessments and best interest meetings had been completed where required. The service had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005.

People told us staff were caring and supported them in a kind and compassionate way. We made observations to support this. People's relatives were mostly positive about the care provided in the service and were complimentary about staff. We reviewed a selection of compliment cards sent to the service that reflected the verbal feedback we received. Staff understood the needs of the people they supported and recognised the importance of using people's care records to understand their care needs. People told us that staff treated them with dignity and respect and gave examples of how staff achieved this. People's visitors were welcomed which reduced the risk of social isolation.

People said the care they received met their needs and that staff at the service were responsive. People felt involved in decisions about their care. Relatives told us they felt involved in care decisions and said the service kept them informed of significant change. Care records were personalised and reflected people's needs. We made observations that care was being delivered in line with people's assessed needs and preferences. The service provided activities and we saw examples of how people had been able to follow their interests and also examples of when people had accessed the wider community. There was a complaints system in operation people felt they could use. People were supported at the end of their life to have a comfortable, dignified and pain-free death.

The registered manager had a vision for the service aimed at delivering high quality care. Staff we spoke with felt valued and supported and commented positively on the proactivity and visibility of the registered manager. Staff felt able to contribute to the service and gave examples of how suggestions they had made had been implemented. People and their relatives were positive about the service management and were happy to approach senior staff if required. There were governance systems to monitor the health, safety and welfare of people. The service received provider level support in monitoring the effectiveness of internal governance systems.

There were systems to communicate with people and their relatives to allow them to share their views and opinions of the service. There were systems to learn and improve and the service worked from a continual improvement plan based on feedback from the provider audits and external agencies. To support the service to continually learn, the registered manager was involved with external agencies and organisations. This included the adult and community services team from the local authority and the local Clinical Commissioning Group (CCG) forum with other registered managers and providers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe at the service.

There were systems to respond to safeguarding concerns.

Risks were assessed and managed in a least restrictive way.

People received their medicines as required.

Learning from adverse events such as accidents was evident.

Is the service effective?

Good

The service was effective.

People's physical and social needs were assessed for positive outcomes.

Staff understood their obligations under the Equality Act 2010.

People received support to eat and drink enough.

The service had complied with Mental Capacity Act 2005 legislation.

People had access to healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People felt well cared for and supported by staff.

Staff took time to understand the needs of the people they supported.

We observed kind and compassionate interactions.

People said they were treated with dignity and respect.

People's visitors were welcomed to reduce social isolation risks.

Is the service responsive?

Good

The service was responsive.

People and their relatives felt the service was responsive.

Care was personalised and delivered to meet people's needs.

People and their relatives felt involved in care planning.

Activities and community access was provided.

People were supported to have a dignified and pain free death.

Is the service well-led?

Good

The service was well-led.

Staff felt valued and supported in their roles.

People and their relatives told us management were approachable.

Governance systems in operation were effective.

The service communicated with people and their relatives.

The service was involved with external agencies and organisations.

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 November 2017 and was unannounced. This inspection was carried out by two 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.

When the service was last inspected in June 2016 no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we found that improvements could be made in relation to risk management, the submission of Deprivation of Liberty (DoLS) applications and overall quality monitoring and governance. During this inspection we found that improvements had been made.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that the provider completes to give some key information about the service, they tell us what they feel the service does well and the improvements they planned to make. We also reviewed the information that we had about the service including safeguarding records, complaints and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people at the service were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the service. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

We spoke with 24 people who used the service and eight people's relatives. We also spoke with 17 members of staff. This included the registered manager, members of the provider's senior management team, care staff and activities staff. We also spoke with one visiting healthcare professional. Following the inspection, we also contacted a healthcare professional and people responsible for commissioning at the service. We received feedback from the healthcare professional we contacted.

During the inspection, we looked at seven people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records. We reviewed records relating to the management of the service such as the staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Good

Is the service safe?

Our findings

People we spoke with were positive about how safe they felt living in the service and with the staff that supported them. The relatives we spoke with also gave positive feedback. One person we spoke with commented, "I feel absolutely safe, no problems at all, I usually have the same staff and they know what to do. I get my medicines all on time and I think they write it up. They do wear gloves for personal care." Another person we spoke with said, "[I feel] Very safe, they come as quickly as they can. We get a lot that I know which is nice. They all wear aprons and gloves." One person new to the service told us, "I have only just arrived here, but yes I feel safe so far."

The service had systems that ensured safe practice was undertaken around identifying and responding to safeguarding concerns. Staff we spoke with knew to contact the registered manager or told us they could contact the police or local safeguarding team with any concerns. They knew where whistle blowing and safeguarding policies were. We saw that where the service had identified concerns, records evidencing the process undertaken to report the concerns to relevant third party agencies were maintained. We saw records that showed where concerns had been raised about hospital discharge procedures and further concerns around the disclosure of personal information by a third party. This evidenced that prompt action was taken to reduce the risk of harm to people.

Risks to people were assessed and monitored. Evident risks were managed in a way that supported people to remain safe, however in a manner that didn't impact on their freedom to be independent. For example, within one person's record it evidenced a pressure mat was used that alerted staff when the person stood on it. Records showed other option's had been considered and discounted including bedrails. The care plan read, "The use of the pressure mat is the least restrictive method of ensuring [person's name] care needs are met."

Individual medical risks had been assessed and planned to reduce identified risk. For example, we reviewed the care records for two people living with diabetes. We saw that a specific diabetes care plan had been created which was in line with nationally published guidance. The plans detailed how the person's diabetes was controlled and the level of support required. It gave staff guidance on what to look for that may indicate the person was unwell. We saw that information relating to the person's diabetic diet was recorded in their nutritional care plan. We highlighted that additional measures could be taken in relation to guiding staff in the different symptoms indicating if the person maybe suffering from hypoglycaemia (low blood sugar) or hyperglycaemia (high blood sugar). We were told this would be implemented in the relevant care records.

Equipment used within the service was maintained. The environment and premises was also subject to safety monitoring to reduce the associated risks to people. For example, hoists and slings were subject to periodic testing and sling inspections were completed. Equipment for weighing people was also regularly calibrated. Environmentally, we reviewed gas safety certificates and saw that electrical sockets were checked. Testing of running water temperatures was completed and there were systems that ensured fitted window restrictors were checked and the electronic nurse call bell system was tested and serviced.

An annual fire risk assessment had been completed in June 2017. Inspection and servicing of the fire alarm had been completed in September 2017. Weekly testing of fire alarms had been completed together with the emergency lighting system. Equipment such as fire extinguishers were serviced and a weekly check of fire exits was undertaken. A check of the "Grab bag" taken in the event of a fire with floor plans and evacuation plans was done. Fire drills were completed. Within people's care records there were emergency evacuation plans and a summary of this was available for the emergency services.

Staffing within the service was calculated using a dependency tool that was reviewed on a three monthly basis. This took into account the individual needs of people relating to matters such as the support they required for during personal care, with mobility, nutrition and if they could display behaviour that may challenge due to their dementia. The deputy manager said that staff were allocated according to needs and skill mix. Allocation sheets for the day were given out daily based on this. The feedback from people and their relatives was mainly positive about staffing and our observations supported this. One person told us, "Yes ,I feel safe here and I feel there are enough staff." Another person said, "Yes I think there are enough staff on duty." A relative we spoke with said, "There is always enough staff about, there's normally always two people in the lounge."

People we spoke with did give example of occasions where staffing had not consistently met their needs. Several people commented that at times their call bell was not answered as quickly as they would like. One relative's comment was, "Yes she is safe but had to wait a long time for the bell to be answered, they said sorry. It's not the same staff but we all natter together." A sample of comments we received from people included, "Yes to safe but not always enough staff on duty. The bell is a long time being answered but they do say sorry" and, "I feel safe and well cared for. The bell is not always answered as quickly as I would like it to be."

Staff feedback was variable about the staffing levels. In the main staff said people's needs were met but comments were received on the sometimes inconsistent numbers of staff on duty. One staff member said, "There seems to be a lot one day and not on other days." The provider had a call bell monitoring system that allowed the registered manager to review call bell response times. This system also detailed the times of the day bells were more frequent and would indicated peak periods where people requested staff assistance. Due to the challenging behaviour of some people in the service we observed, it was evident through observation and through staff conversation that people's needs were variable throughout the day.

We recommend the provider reviews the frequency of dependency assessment reviews to ensure people's needs are consistently met at all times of the day.

The provider operated safe recruitment procedures and ensured all pre-employment requirements were completed. Staff files had completed initial application forms together with the staff member's previous employment history and employment or character references. Photographic proof of the staff member's identity and address had been obtained. An enhanced Disclosure and Barring Service (DBS) check that ensured the applicant was not barred from working with certain groups such as vulnerable adults had been completed.

People told us they received their medicines on time and no concerns were raised. The service currently used an electronic medicines monitoring system (eMAR). This system is operated through mobile hand-held devices used by staff when administering medicines. The system contains pictures of people, and colour codes when their medicines are due, overdue or an "As Required" (PRN) medicine such as paracetamol. The system is also designed to alert staff to when medicine prescription supplies are low and a product requires re-ordering.

During medicines rounds, we observed staff undertook safe practice. Staff administering medicines wore a tabard to indicate they should not be disturbed. We observed that people were given their medicines individually with water and time was taken be the staff member supporting the person with their medicines taken to ensure the person received their medicines at their pace. We observed the medicines trolley was always secured before leaving it in any way and was stored safely when not in use.

When reviewing medicines that required additional storage measures, we saw this was stored in line with requirements. We undertook a stock balance check of some of these medicines against the manual register in use and the balance was correct. We undertook a balance check of medicines stored in the medicine trolley against the eMAR system and these balances were correct. Medicines were stored in a temperature controlled environment and temperatures of the medicines room and refrigerators used for cold storage were completed. Liquid medicines were dated when opened with an expiry date recorded on the bottle to ensure it was not used past the manufacturer's guidance. Staff received competency assessments in administration of medicines and there were effective auditing systems in operation.

Where people received their medicines covertly, this was done in line with procedure and legislation under the Mental Capacity Act 2005. We reviewed a sample of records for people who received their medicines covertly. Mental capacity assessments were completed recording the person's capacity level about their understanding of the need to take their medicines. We saw that where people were not deemed to have capacity, best interest meetings were completed about covert administration. These were completed with the person's GP, members of staff and family members or representatives. Covert administration records were signed by the person's GP and supporting communication from the dispensing pharmacist was sought about crushing or modifying the original state the medicine was dispensed in.

The service was visibly clean and hygienic and there were arrangements for making sure that the premises were kept clean and hygienic. Housekeeping staff understood their roles and cleaning records were maintained evidencing where cleaning had been completed. The laundry room was purpose built and large washing machines had all necessary washing temperatures to prevent cross contamination. Red bags were used for soiled laundry. There was liquid soap and hand towels available in toilets and pedal bins were operated to reduce cross infection risks. Staff were observed wearing equipment such as gloves and aprons when providing personal care and staff told us that such equipment was always available. People we spoke with told us that staff always wore protective equipment when supporting them. Auditing of infection control was completed.

There were systems to learn from adverse events. Records showed that staff understood how to report and record safety incidents such as falls. There were systems to review matters such as safeguarding referrals and falls. Accident and incident monitoring was completed and records were reviewed by management. These recorded information such as what had happened, the level of injury and what action was taken. This included referrals to external healthcare professionals where needed and this information was communicated to staff.

We saw additional reviews were completed in relation to an incident involving defective mobility equipment. Evidence reviewed showed the provider was proactive in identifying risk to a larger audience. Following a moving and handling incident, information was immediately communicated to other services in the provider's group to highlight a known risk associated with a specific product. Contact was made with the equipment supplier and people's moving and handling plans were reviewed and updated where necessary. Additionally, information relating to the related equipment and the potential risk was communicated to Medicines and Healthcare products Regulatory Agency (MHRA) which is an agency of the Department of Health.

Good

Is the service effective?

Our findings

People we spoke with were positive about the effectiveness of the care they received and the abilities of staff that supported them. Nearly all of the relatives we spoke with were very positive about care provision, where this was not the case the service were currently addressing concerns. One person we spoke with, when asked about the staff told us, "Yes, they seem competent and skilled, they always ask my permission to do anything like giving me a wash. They give me plenty to eat and drink. If I want to see a GP I just ask." A person's relative we spoke with told us, "They are all on the button. Mum is never ignored."

Care records showed people's physical, mental and social needs were assessed to achieve effective outcomes. Within people's records we found that risk assessments had been completed in relation to skin breakdown, falls, mobility, hydration and malnutrition or obesity. Assessment tools included nationally recognised tools such as the "Waterlow" tool for skin breakdown and the "Malnutrition Universal Screening Tool" (MUST) for obesity and malnutrition. Other tools, including nationally published guidance in relation to nutrition and hydration were also used. We saw there was a system to review people's risk assessments monthly to ensure they were accurate and reflected the person's current needs.

The service had processes in place to ensure there was no discrimination, including in relation to the protected characteristics under the Equality Act 2010. Staff had a good understanding of equality and diversity and the provider had ensured training in this was delivered. Staff we spoke with were able to describe the protected characteristics under the Act, and other staff spoke of meeting people's individual needs through care planning, understanding their life histories and getting to know people as individuals.

The service had ensured staff had the right skills, knowledge and experience to deliver effective care. Staff spoke positively with us about their training and told us they felt supported. We reviewed the current training record that showed training had been completed in key subjects such as moving and handling, emergency first aid and bi-annual update training in subjects such as infection control, health and safety, safeguarding and food hygiene. Staff received training in dementia and challenging behaviour. Additional online dementia training was accessible for staff and records showed this had been undertaken by some.

New staff completed an initial five day induction with the service encompassing learning about the mission statement and values of the provider and also mandatory training. Where required, new staff complete the Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. Staff received supervision and performance discussion during the early stages of their employment. There were systems to ensure that staff received ongoing individual and group supervision and an annual performance appraisal during their employment. Staff confirmed they received this and we reviewed records that supported this.

People were supported to eat and drink enough to maintain a balanced diet. The service had qualified chefs on duty at all times. We spoke with a chef who said they had received training at the service from a nutrition specialist and we saw records to confirm this. The chef explained they wrote the menu following feedback from people's meetings and any other feedback they got at any other time. They changed the menu

following the meetings or seasonally. The chef explained how they always visited new people arriving at the service to know and understand their preferences and always consulted people about the Christmas menu. They asked people what was their favourites types of food they liked in the evenings. This evidenced people were involved in decisions.

People were supported to have a balanced nutritious diet at the service. The chef told us they provided a lot of fortified drinks to people to help increase their caloric intake and also that they gave people smoothies and ice cream of their liking to support them. We saw that special or modified diets were catered for. Where people had complex needs, input from a Speech and Language Therapist (SALT) had been given and people had a modified consistency diet and this was followed. A safe swallow plan was also noted within the person's care records. We saw one person received a diabetic diet and a vegetarian preference was catered for. Where a person preferred to eat smaller finger foods their preference was met. Communication of special dietary needs (especially regarding safety) was well managed using a symbol system which was clear for kitchen staff and care staff.

We saw evidence that staff worked together to ensure people received support when they were referred to different services. Records communicated people's healthcare needs for staff and a daily handover between shifts ensured key messages were communicated. People also told us they received the support they needed during appointments or external care provision. One person we spoke with commented, "If you have an appointment at the dentist or the hospital they will come with you." Another person who visited hospital frequently told us they were supported by staff. We saw that people's ongoing healthcare needs were monitored during care provision and records evidenced this. Where required, we saw that referrals had been made to external healthcare professionals such as a GP, the district nursing team or a SALT.

People or their relatives did not raise any concerns about the adaptation, design and decoration of premises. When we spoke with people's relatives, some commented positively on the open space within the service such as the wide corridors and spacious communal areas. The service consisted of four separate areas, each with its own dining and communal area. There were rooms for visitors to meet people or for people to talk in private with visitors. Each person had a private, en-suite room which again allowed for privacy should people want it. There were gardens and an outdoor courtyard. Internally, the large lounge areas were spacious and there was a variety of different types of seating including sofas, bucket chairs and arm chairs.

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

Care records showed that people's capacity had been considered when the need was identified. For example, within people's care records capacity assessments had been completed in relation to people's understanding of them living at Buxton House and their ability to be involved in care planning. We saw an assessment had been made as to whether a person had the capacity to decide whether a sensor mat was used in their room to alert staff to their movement and help keep them safe. The outcome of the assessment was that the person did not have the capacity to make this decision. As a result, a best meeting was held with relevant others including the person's relative and their GP about the use of the mat.

Staff had received training in the MCA and were observed offering choice and empowerment to people during the inspection. We observed that choices were offered to people in relation to where they spent their

time and what they did. People were supported by staff to make choices, for example people were told who was in a particular communal room to help them make a decision about going in the room. At meal times, people were presented with a choice of plated meals in order to visually assist them in deciding what to eat.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care services is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

An effective system was in place that showed who had a DoLS application and the status of their application. The service currently had five authorised DoLS application and a further 38 applications were pending local authority action. The system used showed when the DoLS expired and when re-applications had been made. Some people had conditions attached to their DoLS authorisations. Conditions specify particular points that the service must arrange or facilitate for the person. Conditions were attached to ensure that a DoLS is in the best interests of the person. On reviewing records and speaking with the registered manager, we found that conditions on DoLS authorisations were met.

Good

Is the service caring?

Our findings

People we spoke with were positive about the staff that supported them and told us they were caring. Most of the relatives we spoke with were also very positive, telling us that when they left the service they were at ease and knew people were cared for well. One person we spoke with commented, "They seem caring and I think they are pretty good here. The care is done how I like it." Another person we spoke with told us, "They are very caring and I get on well with all of them." A relative we spoke with commented, "I'm really happy [person's name] is safe. When I go home, I go home very happy and content."

We reviewed the compliments folder at the service. This evidenced that people, their relatives or representatives had taken time to communicate their satisfaction with the service. We reviewed a selection of the compliments and recorded some extracts. One read, "I would like to say thank you to all the staff at Buxton House who have cared for Nan, especially those with her in her final hours." Another read, "We as a family just wanted to give our thanks for all the love, care and attention you gave."

Staff knew the people they were caring for very well. During discussions, staff demonstrated that they understood people's care needs as well as their preferences and personal life histories. They knew what person centred care was and described how they ensured that people's choices were met. Staff told us they took time to read and understand people's care records to assist them in giving personalised care. The care plans we reviewed were detailed and informative. Staff said they knew where to look for the information they needed about people.

Staff showed concern for people's wellbeing in a caring and meaningful way, and were observed responding to people's needs quickly. We undertook observations of care provision in two separate lounge areas at different times of the day. Some people at the service were not able to tell us about their experiences, so undertaking observations helped us understand people's experiences of the service. During these observations, we observed positive care experiences for people. We observed that people were treated with genuine warmth and affection by staff and care was delivered at relaxed pace with people being treated with respect and inclusion.

Where people became distressed, we saw that staff understanding the person's needs ensured the distress was addressed and deescalated quickly. For example, staff responded when a person needed emotional support. We observed one person was visibly upset at the lunch table. Recognising this, a staff member went and fetched a comfort doll for the person and then spent some time talking with the person about their comfort doll. This quickly reduced the distress the person was in. This evidenced staff knowledge of people's individual needs. We also observed positive reassurance being given to people during periods of moving and handling when people were supported with mobility equipment such as a hoist.

All of the people we spoke with told us they were treated with dignity and respect by staff. Staff understood the importance of providing dignified and compassionate care. One staff member we spoke with about the standard of care told us, "I think the care here is really good." Another staff described it as, "Good quality of care." One person's relative said, "She's treated as I would treat her." People spoke with us positively about

privacy and dignity. One person said, "Yes they preserve my dignity and they always close the door in the bathroom." Another said, "Yes, they show me respect always and preserve my dignity when they can. The care plan is all taken care of but nothing to worry about. If I ask for anything I get it usually. I wouldn't leave here if they asked me, I love it here."

People could be visited by their friends and relatives at any time of day. There were no restrictions on people's relatives or friends visiting the service and relatives were welcomed. This meant that people living in the service were not isolated from those closest to them. During our inspection, several visitors came to the service. It was clear that staff knew the visitors well when we heard them speaking with them. Relatives we spoke with were all very positive about the way they were treated and felt comfortable visiting at any time of the day.

Good

Is the service responsive?

Our findings

People, or those acting on their behalf, felt involved in care planning and decisions. One person we spoke with told us, "Yes I feel involved in my care but I can't give any example of how. I have not had any complaints." Another person commented, "Yes I feel involved in making decisions about my care. I can always ask a senior member a question if I have a query and get an answer - that helps." During our conversations with relatives, they told us they felt involved. One said to us, "I've never had any doubts about this place - I'm involved because my wife can't be."

There were systems in place to ensure that people's care records reflected their physical, mental, emotional and social needs. Care records we reviewed were personalised, containing information about people's life histories and this information was known by staff. We observed that the information contained within people's care records was used by staff when supporting them. For example, staff described who did not want personal care from male care staff and said this was honoured. A visiting healthcare professional we spoke with told us they had made similar observations of care being delivered as planned. This showed people had choice and control where possible.

We saw examples of where people were supported to follow their interests and take part in activities relevant and appropriate to them. We spoke with some members of the activities staff. They were very enthusiastic and told us activities were provided over seven days a week. On the day of our inspection, people were making Christmas bunting in the lounge and we also observed lots of notices of the daily activities available in rooms and on notice boards. Staff explained how they did a, "One to One" with people who preferred to stay in their bedrooms. These included activities such as active mind puzzles.

The service was part of the "Oomph" activity scheme. This is an exercise scheme for older adults within care homes and other social care settings. In addition to this, the service also had a police dog handler attend the service with a police dog which people enjoyed. One relative we spoke with told us the service ensured their relative went into the community and did things they enjoyed. They commented, "[Person's name] was out having cream tea earlier, they make sure she's got things to do."

Other people were positive about being visited by people in the wider community. There were pictures of when people had visited the local community and had eaten together in a local restaurant. The service was able to give examples of how people's interests were taken into account during activity provision. For example, one person was a former footballer and had been visited by professional footballers. We saw images of the person playing football with the football players. Another person enjoyed playing musical instruments and was encouraged to play their harmonica and his guitar. Another person who enjoyed singing was encouraged to sing when visiting entertainers attended.

There was a complaints system in operation. Policies and procedures were available for people and those acting on their behalf to raise a complaint at the service. The policy detailed how complaints would be handled and investigated and how the complainant would be informed of any subsequent investigation. Most of the people we spoke with knew how to make a complaint or raise concerns and said they would feel

comfortable doing so in their own way. One person said, "I have no complaints but would complain if I needed to - and not feel wrong doing it." Another person said, "I would complain happily if necessary but never had to."

We reviewed the complaints records at the service which showed they had been handled proportionately and in line with policy and guidance. The complaints file evidenced how matters had been promptly addressed and responded to. One complaint we reviewed showed how a concern about the laundry had been raised and this had been resolved by way of a meeting. Other matters had required a full investigation by the registered manager and further matters had been dealt with promptly on the telephone and a record made detailing the outcome of the telephone call.

There were systems to support people at the end of their life to have a comfortable, dignified and pain-free death. We reviewed people's care records relating to their end of life care wishes and preferences. Where people had chosen to have this conversation with staff at the service, their end of life care plan was recorded. Where plans were in place, we observed that people's needs and preferences were being met as far as it was possible to ascertain. Where required, the district nursing team were closely involved in pain relief and they provided staff with support. We saw that where the service had identified people were near the last days of life, and where their condition may be unpredictable and change rapidly, pain and distress management had been planned for and the necessary medicines were readily available.

Good

Is the service well-led?

Our findings

The registered manager told us there was a vision for the service to deliver high quality care. Staff we spoke with were positive about their employment. We spoke with the registered manager about how they ensured people at the service received quality care. They told us, "We look at the bigger picture to what we do, such as a lot of pre assessment so people can live together well." A member of staff we spoke with when asked about the openness and visibility of service management told us, "The registered manager is very proactive and out and about on the floor. She does daily care plan checks and tasks to support the staff." A further comment was that the registered manager had, "A very open door policy."

People and their relatives gave positive feedback on the visibility of service management. We did receive some feedback from people who told us they weren't aware of who the manager was, however these people told us this did not have any impact on them. For example, one person said, "No idea who the manager is and I don't wish to. Nothing can be done better here and they are all approachable." One person we spoke with commented, "Yes I do know the service manager, I have never filled in a questionnaire before now and we do have residents meetings. They are approximately every six weeks and we are encouraged to join in. I find the management team easy to talk to." A relative we spoke with commented, "I have a great relationship with the manager here, I can't thank her and her team enough." Another relative told us the management were, "Very good and very approachable."

We spoke with staff about how they felt in their employment and if they felt valued and supported. We received a positive response. Staff said they knew what was expected of them and that they could go to a team leader or any manager at any time because they were all very approachable. One staff member we spoke with told us there was, "Good team work." We spoke with staff about the support they received at supervision. One told us, "They are quarterly and good, especially if you have any concerns. It helps us build relationships." We asked staff about the openness and constructiveness of meetings, and they commented positively with one staff member telling us, "You can raise points at the meetings." Staff gave examples of when they had made suggestions to adapt or improve the service this had been listened to and acted upon. They gave examples including the use of dining room assistants and the acquisition of laundry equipment.

Governance frameworks in use ensured that responsibilities were clear and that risks to the health, safety and welfare of people were managed. The service operated a governance system that evidenced it was effective in identifying and monitoring risk. Further additional support was received at provider level from senior figures. We reviewed records that showed medicines audits were completed via the electronic system in operation. In addition, infection control audits had been undertaken together with health and safety auditing including an effective falls and incidents analysis as highlighted in the 'Safe' section of this report. There was a system to ensure care records were regularly audited at a consistent frequency. The records we reviewed showed this had been effective and where the need for change or update had been identified this was communicated to staff and records had been updated accordingly.

Provider level support had been provided to ensure internal governance systems had been effective. The service was supported by the quality and compliance team quarterly and an operations manager

completed regular support visits. We reviewed the audit records from the most recent operations manager visit in October 2017. These showed that observations of interactions between staff and people were completed, together with obtaining feedback. A review of care records and records relating to the management of the service was completed together with observations of the service from a cleanliness and health and safety perspective. No key concerns were identified at the last review.

The service had ensured people using the service and their representatives were communicated with and could share their views and opinions of the service. People we spoke with told us they felt the service was open and that they could approach management or staff. The service held meetings with people and their representatives to communicate the direction of the service and to involve them in development and the sharing of ideas. We reviewed the recent minutes of some meetings. We saw in the October 2017 meeting, a senior member of the provider's staff had attended and communicated the current progress of Buxton House, how relationships with healthcare professionals such as GPs had been developed and how changes had been made following feedback. We saw that during previous meetings, people such as a GP and senior figure from the local authority had attended to speak with people or their representatives and answer questions.

There were systems to continually learn and improve. The service had a continual improvement action plan that was created from learning identified from internal governance, provider level auditing and external agencies, for example the local authority. We saw the current improvement plan had improvements noted in care planning and record keeping, dementia care training, record completion by staff and pathway tracking for incidents and accidents. The action plan highlighted how matters recorded had been identified, how to address them and the current progress. The improvement plan was also subject to progress monitoring during provider level audits.

To support the service to continually learn, the registered manager was involved with external agencies and organisations. For example, a quarterly meeting was held with the adult and community services team from the local authority. The registered manager attended the local Clinical Commissioning Group (CCG) forum with other registered managers and providers. This addressed matters such as any changes in any local community hospitals and flu contingency planning. The registered manager was also registered with 'Skills for Care' which communicated information about good practice frequently. The service had also been part of a 'Care Resilience Scheme' and had secured support in enhancing the services knowledge in relation to nutrition, hydration and swallowing difficulties. As a result, the service received funded support from the scheme and was provided with access to a dietician who visited and provided training. This benefited people at the service in the support they received with eating and drinking. The chef we spoke with spoke positively of this training and support provided to them.