Maria Mallaband 12 Limited

Buckingham House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 08 and 09 February 2016. It was carried out following on-going concerns since our last inspection around people's safety. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Buckingham House' on our website at www.cqc.org.uk. It was an unannounced visit to the service.

We previously inspected the service on 28 September and 02 October 2015; the service was not meeting the requirements of the regulations at that time. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We asked the provider to send us an action plan detailing how they intended to improve. The provider told us the actions would be completed by 30 January 2016. At this inspection we checked if appropriate improvements had been made. we found continued breaches in the Health and Social Care Act 2008.

Buckingham House is a care home which provides nursing care for older adults some of whom are living with dementia. It is registered to provide accommodation for 58 people. At the time of our inspection 36 people lived at Buckingham House.

The service had a registered manager in post. 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. However the registered manager had not worked in the service for some time. We had previously asked both the registered manager and the provider to ensure that an application to de-register was made. To date this application had not been made successfully.

People were not protected from avoidable harm, as systems were not in place to ensure people's safety. The local authority was investigating a number of safeguarding alerts concerning people who live at the home.

Medicines were not managed and stored in a safe way, which led to people not being given medicine prescribed and their health and welfare being affected adversely.

People were not always supported with the care they required as care plans did not always reflect their current needs.

The service was not well-led; it had not had a stable management structure in place, although recent changes to management had had a positive impact. However, the provider told us that they would complete a number of actions by the 30 January 2016 to improve people's care. We found that these actions had not been completed in full.

Staff were knowledgeable about people living at Buckingham House, and we noted some good interaction

between people and staff.

Following this inspection we issued an Urgent Notice of Decision to restrict new admissions to Buckingham House whilst the provider makes improvements to the service.

We have made recommendations about the management of complaints, infection control, gaining consent, training on dignity and fire risk management.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We found a Breach of The Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were placed at risk of harm as medicines were not managed safely.

People were not protected from avoidable harm and the local authority was investigating a number of safeguarding alerts.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not supported by staff who always received appropriate supervision and support. This meant they were cared for by staff who had not kept up to date with good practices and safe ways of working.

People had access to food and drink throughout the day.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives were not always included in decisions around their care.

Staff demonstrated some kindness. We observed some good interactions between staff and people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care, as care plans did not reflect current care needs.

There was a lack of meaningful activities provided.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of stable management, which meant that a number of the requirements under the Health and Social Care Act and Health and Safety at Work Act 1973 were not undertaken.

Accurate records of care and treatment required were not maintained to the standards set out by the Nursing and Midwifery Council.

Buckingham House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 08 and 09 February 2016 and was unannounced; this meant that the staff and provider did not know we were visiting. On the first day of the inspection, the inspection team consisted of two inspectors, a specialist advisor within older people's care 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. On the second day of the visit the inspection team consisted of one inspector and the same specialist advisor.

Before the inspection we reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with 14 people who lived at Buckingham House who were receiving care and support, 15 relatives; the manager, deputy manager and quality co-ordinator. We also spoke with 12 staff members including qualified nurses, care staff and non-care staff. We reviewed five staff files and 14 care plan files. We looked at incident reports and complaint records within the service and cross referenced practice against the provider's own policies and procedures.

We contacted the local authority contracts team after our site visit and spoke with two healthcare professionals.

Inadequate

Is the service safe?

Our findings

At the previous inspection on 28 September and 02 October 2015, we found that medicines were not managed and stored safely. The service did not manage as required medicines (PRN) in a safe way and no direction was available for staff on when to administer PRN medicine. We asked the provider to send us an action plan on what they intended to do to make the administration of medicines safer. They told us that improvements would be made by the 30 January.

We checked the actions the provider told us they would introduce to improve safety. We found that no significant improvements had been made and that medicines were not managed or administered safely. Prior to the inspection the service had recently changed the way medicines were managed. The manager advised us that the recently introduced electronic method did not work and had failed to support people with their medicine safely. However, the changeover had caused some confusion in which records were used. We were advised that the confusion would be resolved by 15 January 2016 as a new medicine cycle would be started.

We observed medicine administration on both occupied floors over the course of the two days of inspection. Qualified nursing staff and senior care staff were responsible for the administration of medicines. People's medicine administration records (MAR) were reviewed. Photographs were attached to MAR sheets to aid identification and any medicine allergies were recorded. When a person had refused or had not received a medicine, the appropriate code had been recorded on the MAR.

On both floors and on both days the staff identified for completing medicine administration chose to not take the medicine trolley around the home. We observed that this meant that medicines were being dispensed quite slowly as each time the member of staff had to dispense the medicine; they had to lock the trolley, lock the store room and go to the person. A tabard was worn to advise people the member of staff was not to be disturbed. However, we observed a member of staff answering the telephone whilst they administered medicine. We found that care staff who undertook medicine administration were easily distracted; we observed them engaged in conversation with other staff and people who were not the intended recipient of the medicine.

We looked at the care records and medicine administration record of a person who had recently been admitted to hospital. We found that the home had failed to administer one of the person's prescribed medicines between the 24 and 29 January 2016. This was because the medicine was not available in the home. Their condition deteriorated and they were admitted to hospital. The nature of their deterioration indicated that the omission of the medicine may have been a contributing factor.

Another person who was due medicine once a week had not been given it. This had not been picked up some three days after it should have been given.

Medicines were not routinely stored safely. On day one of our inspection we found the medicine store room unlocked and the keys were found in the door of the medicine trolley which was also unlocked. This meant

that people who were confused due to a dementia illness could have had access to medicines. We observed that the medicine fridge was not locked but had current medicine within it. A twice-daily record of temperature was not routinely maintained. There were locked cupboards to store extra medication. The medicine store room was cluttered with past records of administration sheets and equipment which was no longer in use.

Within an unlocked cupboard (not designed to lock) Paracetamol and Lemsips where found, these were unnamed and when we asked the manager they stated they should not be there and they were removed.

Risk assessments and protocols for medicine administration were either not present or did not provide sufficient detail to the staff to ensure safety. Where additional observations were required prior to the administration of medicine this was carried out. However, the staff were not clear on the importance of these observations and the threshold for medicine to be withheld.

One person was receiving anti-coagulation therapy. The information available in the MAR file did not clearly indicate the dose of Warfarin that person was to receive, as it was out of date. A record book had been provided in which to record blood test results and dosages, but this was not filled in. A letter detailing the correct dosage was found in the medicine store room. The MAR indicated that the person was receiving the correct dose.

Individual protocols for the use of PRN medicines were not kept with people's MAR sheets, nor available in people's care plans. The use of protocols for PRN medicines directs staff as to when, how often and for how long the medicine can be used and improves monitoring of effects and reduces the risk of misuse. The providers policy regarding PRN medicines stated that 'the requirements for the administration of such medicines must be reflected in each care plan in order to provide information and advice for staff as to what it is and when administered.'

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, as the service did not ensure proper and safe management of medicines.

People who lived at Buckingham House were not always protected from potential abuse. The local authority was investigating the care and treatment provided following hospital admissions for people who lived at the home. The outcome of the investigations was not known at the time of our inspection. The commission had received a further 19 safeguarding concerns since our last inspection of Buckingham House.

The provider did not ensure that all safeguarding concerns were reported to the local authority. We saw that an incident involving two people where one person had been pushed over by another was recorded in an accident book. However, no referral had been made to the local authority. This meant that the incident was not investigated to identify and prevent potential future abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, as the service did not ensure people were protected from abuse and improper treatment.

Staff we spoke with were aware of how to recognise signs of abuse and advised us that they would report any concerns to the management. Staff knew who they could contact if they had concerns about the manager or provider. We noticed there was no information displayed in communal areas about how to report. However, people we spoke with stated they felt safe. Comments included "I feel safe but you're mixed in with people you're not used to," and "I feel safe, although I do hear noises at night."

The service did not ensure that people were protected from avoidable harm. We found evidence of some risk assessments; however, these were not clear in severity and actions required. Risk assessments were not sufficiently recorded and the completion of them varied from fully complete to complete in part to not completed and did not provide staff with appropriate advice on how to reduce accident and incidents. For instance, we reviewed the care records of one person who had been assessed as being at high risk of falling. Their care plan did not fully identify the risk factors or the interventions required to reduce risk. Their mobility had been assessed prior to admission to the home. This indicated that they had a history of falling and poor mobility.

A falls risk assessment had been completed on admission in October 2015, which indicated that they were at high risk of falling. The risk assessment had been reviewed again in November 2015 and January 2016, but not monthly. The assessment form stated that if a person were deemed at high risk of falling then staff should 'Identify modifiable risk factors in care plan.'

A care plan relating for mobility was in place, which was dated 26 November 2015. This recorded three interventions, which were as follows: That the person required the assistance of one carer to walk independently. That their call bell to be in reach whilst in bed to avoid getting out of bed on her own and falling. The third entry read 'Has scoliosis, requires straw to drink.'

A moving and handling assessment had been carried out that recorded that the person required assistance from one to two staff to mobilise and a walking aid. The assessment had not been signed or dated.

Another person who was being supported with a one to one care worker due to their high levels of aggression did not have accurate and up to date information recorded. The person had a behaviour record (ABC chart). The last recording on this was 25 December 2015. However other records showed further incidents had happened since then which were not noted on the behavioural chart.

The service did not ensure that all accidents and incidents were recorded; this meant that management were not aware of these events and no investigation was made to prevent future events. For instance, we found that only some accidents and incidents relating to one person who was at high risk of falls were recorded. The person's daily record indicated that they had been found lying on the floor in their room having fallen trying to walk from their chair to their bed. Another time, it had been recorded that they had bruising to both their hands. A third incident recorded was that the person had stated that they had been hit by a care worker. Lastly, it was reported that they had bruising on their hip. We looked at the home's incident and accident book and found that none of these occurrences had been reported and the manager was unaware of them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, as the service did not ensure care and treatment was provided in a safe way.

We reviewed staffing rotas and asked people, their relatives and staff about staffing numbers. We received some mixed responses from staff. Comments from staff included "staffing has improved" and "we could do with more staff." We asked the manager about staffing levels, they showed us a dependency tool which was used to calculate staffing numbers. The provider produced guidance on safe staffing numbers. The staffing levels at the home were within the limit assessed by the provider. However, rotas did not always display an accurate picture of staff who had worked. For example in the week prior to our visit, staff who did not attend work were listed as worked and staff who worked were not listed. This meant that the management did not have an accurate record of who had worked. We asked the manager when they completed the staffing tool, they advised us that this was completed retrospectively using records. This meant that the validity of the

aggregation tool could be compromised. The provider had introduced a new role to the service. A 'hostess' role had been created. We were advised by the quality co-ordinator this had been introduced to support staff at meal times. Staff we spoke with felt this addition was positive and had helped them.

We observed there had been an increase to domestic staffing levels. Domestic staff were visible throughout the two days of inspection. We noted a pungent offensive odour on the ground floor on both days. After cleaning this dispersed slightly. We noted that some rooms were carpeted which could have contributed to ineffective cleaning. Staff we spoke with stated that in the past meetings had been held with family members to discuss hygiene and floor replacements. Domestic staff we spoke with had a good understanding of good practises for infection control. However, care staff demonstrated a mixed understanding. One member of care staff was observed to be wearing nail varnish, which did not promote good hand hygiene and other staff were observed not to be wearing an apron when supporting with food. This meant that there was a potential for cross contamination.

We recommend the service provides the staff with additional information and training on good hand hygiene.

We observed that where equipment was used this was maintained to a safe standard and regular checks were completed. The service had up to date safety certificates for fire equipment and electrical equipment. However, we found that the fire procedures had not been routinely followed. We found gaps in recording of weekly fire alarm checks being carried out. For instance no recordings had been made between 01 January 2016 to 18 January 2016. We spoke with the person responsible and they advised they were new into post. They advised that since in post this had improved. Records reflected what they told us. However, the provider had failed to ensure that fire safety was maintained prior to the staff member's appointment.

We recommend the service takes into account best practice in fire risk management.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 28 September and 02 October 2015, we found the service did not ensure relatives acting and signing on behalf of resident had the legal authority to do so. We previously asked the provider to tell us how they would improve this area. They sent us an action plan, which detailed the changes they identified. They told us that they would make the changes by 30 January 2016. We found that actions had not been made to ensure significant improvements were in place. For example we looked at four peoples file and they did not contain fully completed records with regards to consent.

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.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found inconsistent evidence that the service undertook mental capacity assessments and made decisions in the best interests of people. Mental capacity assessment were not always fully completed, dated or signed. We found that some documents were signed by relatives; however, no evidence was seen to demonstrate they had the legal authority to do this.

We observed staff seeking general consent from people when supporting them. However, this was not demonstrated in the daily records of support provided to people.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

People did not always receive effective care. It was not always clear exactly what help and support people needed. The assessment and review processes were not clear, and it was not clear what tools had been used to assess an individual. There was a lack of joining up of information and that gave the reader an unclear view of need. For example, one person who had a diagnosed dementia, had little information recorded in their care plan as to how this condition was to be managed or any detail of indication that the condition had progressed. There was no clear rationale for introduction of one to one support, when it would be reviewed and what the outcomes for that action were.

We looked at the records of another person whose condition required the use of a dietary supplement and thickening agents. The notes did not explain why these were required how and when they were to be used

and what the intended outcome was. In addition, the person's medicine was in liquid form and there was no link to the swallowing difficulties and the medicine other than to say the person's GP had stopped unnecessary medicines.

Staff told us they had to complete a set of e-learning prior to the commencement of them working with people. This was confirmed by the manager. Some training was completed face to face. On day one of our inspection we observed manual handling training being held. Staff training was not routinely completed as stated by the provider's own policy. For Instance, one staff member who was responsible for medicine administration informed us they had not received any training on medicine; we reviewed their personnel file and spoke with the manager who confirmed that they had not received training on this. This meant that the provider did not ensure that people were skilled in areas required which had the potential for mistakes to be made. When asked how often staff competency to administer medicines was checked, the deputy manager and nurse were unsure of the frequency. The deputy manager said that they were currently "looking at doing" competency assessments and that some had been planned. The registered provider's policy stated that competency to dispense medicines should be checked prior to the staff member dispensing for the first time and every three months thereafter.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. As the service did not ensure staff had appropriate training to ensure safe care and treatment.

New staff to the service were expected to complete an induction; this involved working through policies and awareness of the service and working alongside (shadowing) more experienced staff. We looked at recruitment files. We found a lack of evidence of an effective induction both for qualified staff and care staff. We asked the manager about this and they could not find a successfully completed induction programme. There was a lack of supervision meetings for staff to discuss their learning and development needs. The manager had identified this as an action and had a programme in place to ensure all would be completed.

The service did not ensure that requirements under the Health and Safety at Work Act 1974 were carried out. Where the service was required to undertake risk assessments for specific conditions, these were not routinely carried out, which meant staff were not supported in their job role and may have been subject to situations which harmed them.

People who lived at Buckingham House were registered with local GP practices. We observed a GP visited the service on day one of our inspection. One person had been recently referred to specialist mental health services, due to a change in their condition. Another person had been referred to the speech and language team (SALT).

People were not always supported to have sufficient to eat, drink and maintain a balanced diet. We noted a general theme of weight loss in people's records. Seven of eight records showed weight loss. We noted that weight loss was not routinely and accurately monitored. For instance one person had a 'MUST' screening assessment and a Nutritional Assessment. In December 2015 it was reported that monthly reviews should be carried out but there was only a total score and no dialogue of review on the care plan other than to say plan remains in place. On the weight record chart it showed a significant weight loss between September and February, 69.4kg down to 61.30kg but that was not reflected on the MUST or Nutritional screen. The weight loss was not reflected in other assessments like the Waterlow. The care plan for nutrition offered clear general advice on what to do, and did not reflect everything in the assessments or needs stated in admission documentation. The evaluation of that plan stated on "10 December 2015 plan was rewritten and needed to be evaluated weekly for next 4 weeks" next entry of the evaluation was 25 January 2016, with no record of any weekly evaluation either on that form or within the daily record. On the 25 January the record

stated "Weight remains stable", however records on the weight chart show a decrease in weight from December to January and January to February.

We noted that snacks and drinks were readily available. We saw that people were supported to access drinks; however people did not always receive the support they required as meals were taken to them in their rooms and staff were not always available to support people with meals. For instance one person had been told that the SALT was coming to observe them at a meal time. This information was relayed by the person to the staff who gave lunch; this was then questioned with the deputy manager who knew nothing about this. When the SALT arrived they were surprised that staff had provided the meal prior to their arrival. This meant that the assessment could have been compromised.

People's comments about food included, "The food is very good, I quite enjoy it and there's plenty of it and I eat nearly everything," "The food is pretty good on the whole and I get enough choice by and large," and "The food has improved but lunch can take a long time."

Buckingham House was a fairly new build, purpose built to provide nursing and residential care. The decoration and design of the home did not lend itself to promoting independence for people who lived with a dementia. For instance, the ground floor dinning/seating area was over furnished, making it difficult for people who could self-propel in a wheelchair. Some improvement had been made to the coffee area on the ground floor which opened the area and we observed a number of people seated in that area.

Requires Improvement

Is the service caring?

Our findings

We observed that privacy was not always promoted. For instance, when staff were administering medicine people were asked personal questions in the presence of others. This meant that confidentiality was not always maintained.

The service had an opportunity to learn more about people as they used a 'me and my life' document, however we found that this document was not routinely completed. We found that care plans were not routinely reviewed. Where they were reviewed people and relatives were not always involved in the process. We did find some evidence that some people were consulted about their care.

In the main staff demonstrated good communication skills, and provided a service that promoted dignity and respect. However, we did observe that on the odd occasion staff entered rooms without knocking or seeking permission from the person. Some staff used 'pet names' for people who lived at Buckingham house. We did not see any evidence that this had been discussed with people and it could lead to offence. We overheard one carer asking a colleague "Is she dementia?" This did not demonstrate respect for the person concerned as it de-personalised them.

People were supported by staff who demonstrated some kindness and we observed some friendly interaction between people and staff. Comments from people included "I find the staff are nice people and it is a reasonable place," "I have a good rapport with most of the staff" and "The staff are exemplary; X is very nice indeed and appropriate."

Relatives we spoke with told us they felt the staff were caring in their approach. Comments included "The staff are absolutely superb and are approachable. She has a good relationship with the staff because she is chatty and I'm impressed how the staff relate to her," and "The staff treat Y with respect."

Relatives told us that resident and relative meetings happened regularly. Relatives we spoke with stated they valued these meetings. One relative who had been unable to attend the meeting was sent the minutes. They advised us they were intending to attend the next meeting.

Staff we spoke with were able to tell us a lot about people who they cared for. However, staff did not always appear to be aware of likes and dislikes. For instance, one person had stated in their plan and other information they did not eat apples or anything containing apples, they were offered apples and custard for their pudding.

The service gathered information on people's preferences towards the end of life. This was evidenced in pre-admission assessments.

We recommend the service looks into providing training of providing dignified care.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection on 28 September and 02 October 2015, we found the service was not appropriately dealing with complaints in a timely manner. We asked the provider to tell us how they would improve this area. The provider sent us an action plan which advised that improvements would be made by 30 January 2016. We found that some improvements had been made since the new manager was in post. However prior to their appointment and since our last inspection we found that complaints had not always been responded to.

The service had a complaints procedure again people gave us mixed responses to how complaints and concerns had been dealt with. One relative told us "Where I have had minor issues, I have been able to come and see [manager], we talk through the issues and these have always been responded to." Other relatives confirmed that they understood how to complain and had access to the manager. From the relatives we spoke with the majority stated that the availability of management to discuss concerns had improved. However, we had received concerns from other relatives who did not feel that the provider had appropriately dealt with concerns or complaints raised. We noted that a number of complaints raised to the provider under the previous management, had not been responded too.

The manager was able to demonstrate how they responded to complaints and kept detailed records of actions taken.

People were not always supported by a service that was responsive. We received mixed responses from people and their relatives. One person told us "They could be quicker in answering the bell; the home is improving very much now, but is slow." Another person told us "I can't think of any complaints and I've nothing nasty to say - so far so good." One relative informed us "They are not stimulated enough – the balloon games are silly." However, another relative told us "The home's facilities were excellent and just what we were looking for."

People did not always receive personalised care, as care plans were not updated and did not always reflect current care and treatment required. For instance, one person had been admitted to the home from hospital, three days prior to our visit. Prior to being in hospital, the person had been living in another nursing home run by the registered provider. A pre admission assessment had been obtained, which recorded some of the person's current needs, but not in any detail. For example 'skin intact' 'Incontinent' and "Uses upper body." The home was using care plans sent from the person's previous nursing home. However, the information was not current. For example; the moving and handling review was dated 21 February 2015. Care plans sent had been last reviewed on 17 December 2015, almost two months prior to the person's admission to Buckingham House. Some information relating to the person's current support had been recorded in the daily report such as 'assist with feeding' and 'hoisted from bed to chair using full body sling.' This meant that staff were providing care and support without having fully assessed the person's current needs.

Another person's care records contained contradictory information, documents that had not been signed or

dated and some that had not been fully completed. They had a pre admission assessment which had not been signed or dated. The document recorded that, regarding the person's mobility; they required 'Intermittent supervision/assist for difficult manoeuvres.' Their assessment on admission stated '3 wheel walking aid and staff to accompany when mobilising, to avoid falls and accidents.' A safe handling care plan/risk assessment stated 'full mobility' 'No assistance required.' This document had not been dated or signed.

Falls risk assessments dated 15 September 2015, 16 October 2015, 20 November 2015 were all indicated a low risk of falling. However, the person's care plan for personal hygiene, which had been in place since admission stated that the person required the support of two staff members and the use of a standing hoist. An entry in their care plan for maintaining a safe environment, dated 29 January 2016 read 'No longer able to mobilise on his own, due to pain.'

We found that the person had developed a pressure sore (Grade 2). This had been recorded on 21st January 2016. A skin integrity care plan was in place, which stated 'review monthly or should any changes occur.' They care plan did not specify if any interventions, such as positional changes or provision of pressure relief equipment, should be provided in order to prevent any further deterioration. A wound care plan had not been introduced and there were no specific records about how the wound had been treated or how it was progressing. There were two entries in the daily notes commenting on the condition of the wound and any treatment provided. The nurse on duty said that about the pressure sore "It was small and dressed with Cavalon." They also said "There should be a photo" in the person's care file, but we were unable to find this.

The person was in hospital at the time of our inspection. There was no air mattress on their bed.
We spoke with manager about the lack of appropriate care planning. They advised us that a programme was in place to review all the care plans and the deputy manager and themselves had completed a number to date. We were provided with a recently reviewed care plan. However, when we looked at this we found that the person had been admitted to the home with pressure sores. Records indicated that they had developed a further sore whilst in the home. The manager was unaware of this sore having developed.

Wound treatment records were available relating to the sores. The person had a care plan for mobility, which recorded information relating to skin integrity. This said that the person's position was to be changed regularly, although the frequency was not specified. The person was to be provided with an air mattress on their bed and a pressure relief cushion for their chair. They were also to wear pressure relief boots on both feet.

We visited the person and found that they had been provided with the appropriate equipment. The person was at in their arm chair on a pressure relief cushion. We noted that one of their pressure relief boots had slipped off. Their air mattress had been set at an inflation pressure appropriate for their weight. There were no records of positional changes being kept. We spoke with two carers who were unable to specify how often the person's position was being changed, but stated that the person was checked every hour. Records of this were kept.

One person who was having support from a community nursing team had no record of what actions had been undertaken by that team. This meant that staff were not aware of the current state of the person's health.

We spoke with the manager about the lack of effective care planning. They advised us that there was a programme in place to review all care plans. However, we looked at two records which had been identified by the manager as updated. We found there were gaps in recording and also some records were undated

and or not signed by the author.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

Inadequate

Is the service well-led?

Our findings

People were supported by a service that was not well-led. There has not been a consistent management structure in place since the autumn of 2014. The provider had failed to successfully de-register the previous registered manager. This meant that the Commission was not informed of important information when it should have. Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. We found evidence of events that should have been reported to the Commission in the form of a notification which were not carried out. One record related to a safeguarding issue, which was also not reported to the local authority. Another record related to a grade 3 pressure sore.

This was a breach of Regulation 18 of The Care Quality Commission(Registration) Regulations 2009, as the service did not ensure the Commission was notified of important events when required to do so.

There was a requirement on providers to be open and transparent. The regulations place specific duties on providers to inform people or their legal representative when 'notifiable incidents' happen, this is required in person and should be followed up in writing. This was a requirement under 'duty of candour'. We reviewed records and we found no evidence that this had occurred. However, the manager had noted that they needed to write to two people regarding recent events. In discussion with the manager it was clear that they had not planned to write to all people required. They also advised us that they had not kept records of initial conversations held.

There was a requirement on providers to display the rating provided by the Commission. We found our rating from the previous inspection was not displayed.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, as the service did not ensure the requirements of Regulation 20 were met.

Some records were specific nursing records. As such, these should meet the requirements set out in the nursing code from the Nursing and Midwifery Council (NMC). We found a number of records which did not meet this requirement. We spoke with the manager about this. We also spoke with the local authority who had previously offered some training on record keeping. Unfortunately this had been cancelled by the previous manager. This training had been re-offered and accepted.

The provider had failed to act upon concerns raised at the previous inspection. We found that records were not accurate or up to date. This led to people not receiving appropriate care. Systems were not sufficiently embedded to provide safe care and treatment. This had led to medicine errors and avoidable events taking place. This had had a direct impact on two people who lived at Buckingham House as they had been hospitalised as a result.

On both days of the inspection we observed people's care plan files were left out in communal corridors. This meant that personal information was accessible to anyone visiting the home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, as the service did not ensure that records were maintain securely and accurate.

The service did not have an up to date business continuity plan, we looked at two copies of previous plans the last one dated 01 April 2015. This did not reflect the current management structure. We also looked a fire evacuation list. This did not reflect the people who lived at Buckingham House. This meant in the event of a fire the situation had potential not to be managed safely.

A quality co-ordinator was in post and we were advised that they regularly visited the home. We noted that a number of audits were undertaken; action plans were written which identified short falls. However, the effectiveness of the audit did not have a marked impact on driving improvements in the service.

We found some evidence that people were included in discussions around their care, and some feedback from relatives in the form of a review meeting. However, this was not consistently provided for all who lived at Buckingham House.

The service did provide resident and relative meetings, which provided an opportunity for people to feedback their thoughts to the provider.

Staff and relatives we spoke with told us that the management had changed for the better. Comments included "We saw six homes before this one and this was better. I can't fault it, but it could be better," and "Things have improved because the concerns from the last CQC inspection were acted upon. The management has vastly improved." Staff felt that they were listened to for the first time and had confidence to go to the manager. One staff member told us "The atmosphere has completely changed. The manager is approachable."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service did not routinely notify CQC of certain event that it was required to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service did not ensure it met the requirements of Regulation 20, as it had not been open and transparent when 'notifiable incidents' had occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The service did not ensure that the previous rating assessment was displayed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not ensure that staff were supported with all the required training to develop them with the right skills to provide safe care and treatment.

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 People were not receiving safe care and treatment, as medicine were not stored or administered in a safe way. Risk assessments were not always updated with accurate information on how to minimise risks. Incident and accidents were not routinely reported through the incident management system.

The enforcement action we took:

Issued an Urgent Notice of Decision to restrict new admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not ensure that system were in place to protect people from abuse. Incidents of safeguarding concerns were not reported to the local authority or CQC.

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 The service did not ensure that systems were in place to assess, monitor and mitigate risk. The service did not ensure records were kept securely.

The enforcement action we took:

Warning Notice