Crown Care IV Limited

Buckingham Care Home

Inspection report

Green Lane
Penistone
Sheffield
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 10 April, 2018 and was unannounced, which meant that nobody at the service knew we would be visiting. The last comprehensive inspection took place in July 2015 when the registered provider was meeting the regulations. You can read the report from our last inspections, by selecting the 'all reports' link for 'Buckingham Care Home' on our website at www.cqc.org.uk.

Buckingham care home 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.

Buckingham Care Home is located in Penistone and has access to the local amenities. The home has 72 bedrooms with en-suite facilities on four residential units, across two floors, including 'Memory Lane' designed for people living with dementia. Some of the bedrooms have direct access to the garden and patio. Within the home there are four lounges, four dining rooms and a café. There is a car park to the front of the property.

At the time of our inspection the service had a registered manager. 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 were safeguarded from the risks of abuse. Staff were knowledgeable about identifying abuse, recording and reporting it. Risks associated with people's care had been identified and staff knew how to manage risks. However, documentation did not always evidence the risks and action staff should take to minimise them. We observed staff interacting with people and found there were enough staff available to meet people's needs in a timely way. Medication systems were in place, however, protocols in place to manage medicines prescribed on an 'as and when' required basis lacked detail. Documentation also needed to evidence that topical creams were being applied as prescribed. Accidents and incidents were monitored on a monthly basis showing a clear audit trail.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. This was because the management team were aware of who had an authorised Deprivation of Liberty Safeguards or if any conditions were attached. Consent to care and treatment was sought in line with current legislation. Best interest decisions were considered but were not always documented.

Staff received training on a regular basis both face to face and online. Staff were knowledgeable about their role. People received a nutritious diet, although documentation for recording this could be improved. People had access to healthcare professionals and staff adhered to their advice.

We observed staff interacting well with people and were kind and considerate. People's privacy and dignity were respected.

People received personalised care and staff were aware of people's needs and preferences. However, this was not always detailed in care records. A range of activities took place but did not always involve everyone. People felt able to raise concerns and complaints were listened to. The registered provider learned lessons from complaints received and took appropriate actions.

Audits were in place to ensure policy and procedures were followed. Audits mainly identified areas of development and these were actioned. However, audits could be more detailed to ensure all outstanding issues are identified. There was evidence that people had a voice and were given opportunities to be involved in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service had deteriorated in this domain and was rated Requires Improvement.	**Requires Improvement**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service had deteriorated in this domain and was rated Requires Improvement.	**Requires Improvement**

Buckingham Care Home

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 10 April, 2018 and was unannounced. The inspection was carried out by three adult social care 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. At the time of our inspection there were 61 people using the service.

Prior to our inspection we gathered and reviewed information about the service to help us to plan and identify areas to focus on in the inspection. We considered all the information we held about the service. We also asked the registered provider to complete a provider information return [PIR] which helped us to prepare for the inspection. This is a document that asks the registered provider to give some key information about the service, what the service does well and any improvements they plan to make.

We spoke with eight people living at Buckingham Care Home and nine relatives who were visiting family members. We spent time observing people going about their daily lives and looked round the home's facilities, including people's rooms, communal areas and bathing facilities.

We spoke with staff including the registered manager, care workers and unit leaders. We also requested the views of professionals who were involved with supporting people who lived at the home, such as the local authority. We also contacted Healthwatch Doncaster. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We looked at people's care records, as well as records relating to the management of the home. This included minutes of meetings, medication records, staff files and quality and monitoring checks carried out to ensure the home was operating to expected standards.

Requires Improvement

Is the service safe?

Our findings

We spoke with people who used the service and their relatives and they were positive that the care they or their relatives received was safe. One relative said, "She [relative] gets good safe care, her possessions are safe as well." Nobody reported any incidents that particularly concerned. One person said, "I have never seen anything to upset me, it's always calm."

The registered provider had procedures in place to safeguard people from abuse. Staff confirmed they had received training in this subject and could explain the actions they would take if abuse was suspected.

Most people and visitors we spoke with felt that there was a need to have more staff on duty, but nobody reported any direct impact on the care given from low staffing levels. One relative said, "There never are enough [staff] but it's adequate." Everybody felt there was a good response to the buzzer or when asking for assistance. One person said, "I haven't been affected, I might wait for three to five minutes." Everybody felt that the level of regular staff was good. One person said, "I basically see the same ones [staff], I haven't noticed any agency ones."

We observed staff interacting with people and found there were enough staff available to meet people's needs. Staff responded to people in a timely way.

All People who were assisted to take their medicines were happy that this was given in a timely manner. One person said, "They give me them [medicines] when I'm supposed to have them."

We looked at the systems in place for managing medicines. This included the storage, handling and stock of medicines and medication administration records (MARs) for people. Medication procedures were in pace to guide staff and ensure safe medication administration. We saw procedures were followed by staff. We saw some very good practice followed by staff when administering medicines.

However, we found where people were prescribed medication to be taken as and when required known as PRN (as required) medicine, the protocols lacked detail. For example, we saw people who were prescribed pain relief to be taken as and when required. Some of the people lacked the capacity to be able to tell staff when they were in pain and the protocols did not give sufficient detail for staff to be able to determine when people were in pain. Protocols also lacked detail for people who were prescribed medicines to relieve signs of agitation and distress. Staff were able to tell us how people presented when they required the PRN medication but this was not fully documented.

We also found the recording of topical creams was not always carried out when they had been applied. For example, we saw in the daily records for one person that they had sudacream applied but this was not signed as applied on the topical MAR. We also found other people's topical MAR's where the creams had been applied but not recorded. We discussed this with the registered manager who told us this had already been addressed but would be discussed again with staff and addressed.

Risks associated with people's care had been identified and staff knew how to manage risks. However, documentation did not always evidence this or detail action staff should take to minimise them. For example, one person was at risk of developing pressure areas and required staff to change their position whilst they were in bed. The risk assessment did not detail how this should be carried out safely or what equipment should be used. We also saw where people were at risk of poor nutritional intake the risk assessment had identified the need to complete a food chart, the food charts were not always completed accurately. Many just recorded ate all, half or none. They did not always detail the snacks offered or how much food was served to be able to determine the actual amount eaten. Staff could tell us the snacks that had been offered and what the person had eaten, but the documentation lacked detail to be able to effectively review and manage the risk.

The provider had a recruitment policy which assisted them in the safe recruitment of staff. This included obtaining pre-employment checks prior to people commencing employment. These included references from previous employers, and a satisfactory Disclosure and Baring Check (DBS). The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people.

We looked at a selection of staff recruitment files and found they contained all the relevant checks. We also spoke with staff who confirmed they had to wait for pre-employment checks to be returned prior to them starting their new role.

Accidents and incidents were analysed on a monthly basis. This showed the registered provider monitored patterns and trends and ensured action was taken to minimise accidents reoccurring.

We completed a tour of the home with the deputy manager and found some issues regarding the cleanliness and maintenance of the home. For example, we saw a shower chair in a corridor which required cleaning and items in store rooms were sometimes stores on the floor (including pillows). This meant that the store room floor was unable to be cleaned effectively. On entering one store room we noticed the floor covering gripper was in need of attention and was creating a tripping hazard. We spoke with the deputy manager about these issues and we were told these would be addressed straight away. However, most people and relatives we spoke with felt the standard of cleanliness and hygiene were good one visitor said, "It is brilliant."

Good

Is the service effective?

Our findings

We spoke with people who used the service and their relatives and they responded positively about the level of training staff received and the quality of care they provided. One relative said, "They seem to know what to do and how to do it." Everybody said the staff asked for consent, one relative said, "They [the staff] always explain what they are doing, even though she [relative] is unresponsive."

The supervision and appraisal processes and training programme in place ensured staff received the level of support they needed and kept their knowledge and skills up to date.

There were procedures in place, which enabled and supported the staff to provide consistent care and support. Staff meeting records demonstrated staff received training, knowledge and understanding around such things as whistleblowing, safeguarding, equality, diversity and human rights. This was also evidenced in supervision and appraisal records.

We looked at care records and found that people had access to healthcare professionals when they needed their support. This included the falls team, dieticians, and the memory service. Advice given to staff was used to support the persons care needs.

People we spoke with felt that there was good access to other health care professionals. One person said, "They [the staff] arrange the doctors and things." The majority of relatives we spoke with felt they were kept informed about referrals and other daily changes which affected their relative. One relative said, "They [the staff] let me know when the doctor called for an ambulance."

We observed lunch being served on all units and found that people received a balanced and nutritious diet. People were also offered drinks and snacks in-between meals. Documentation for recording food and fluid intake could be improved for people who required staff to monitor their food and fluid intake. We saw that there were occasions where people's food and fluid charts were not completed and times were they did not contain enough information. We spoke with the registered manager about this and they took appropriate action.

Everybody we spoke with made positive comments about the cooking and the quantity of the meals. One person said, "Pretty fair, there is enough to eat, there quite a few choices, they [catering staff] will make an alternative, I have toast sometimes." Two visitors said that the kitchen was making an effort to provide different diets, "They have bent over backwards to give [our relative] food she can eat easily." Everyone living in the home said that they were weighed regularly, "I get weighed every week." Everybody said that there were snacks and drinks available between mealtimes one visitor said, "She [relative] always has a drink, they are good at providing home cooked cake."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 that consent to care was sought in line with legislation and documented in care records. Best interest decisions had been considered and documented where required.

People who used the service told us they made their own choices about their day, one person said, "I choose to go to bed when I want."

Good

Is the service caring?

Our findings

We spoke with people who used the service and their relatives and they told us they were happy with the quality of the care given by the staff. They thought people were treated with dignity and respect. One relative said, "They [staff] are generally kind and caring, very nice, treat me respectfully, one is really lovely." One person said, "They [staff] treat me respectfully, they are kind and caring." Another person said, "They [staff] are wonderful, they bend over backwards, lovely girls."

Relatives felt that they were actively involved in their relatives care. One relative said, "I get involved in her care, I know when she is not herself." The majority of relatives were happy with the level of communication from staff. One relative said, "They have the time to chat about the care, they are more than happy to discuss it."

People who used the service felt their relatives were made feel welcome when they visited the home. One person said, "They [staff] make them feel welcome, they ask them if they want a drink." A relative said, "They [staff] are relaxed about visiting times and how long I stay."

Relatives told us that their family members were always well dressed and clean, "She [relative] is well presented and groomed when they get her up." Relatives felt that as far as possible people were supported in being as independent as possible. One relative said, "She [relative] is actively encouraged to do more."

We spoke with staff and they were able to explain how they supported people and maintained their dignity. Staff spoke with respect for people and told us how they closed curtains and doors to preserve dignity. Throughout the inspection we observed staff interacting with people in a kind and caring manner. We saw staff knocked on doors prior to entering a room.

The service had champions in place to lead on topics such as dignity, dementia and infection control. These staff offered guidance for the rest of the staff team and received regular updates which they shared with the staff team.

Good

Is the service responsive?

Our findings

Most relatives we spoke with said they had made preliminary visits to the home, one relative said, and "We chose it over about six other local ones." Only one relative said that they knew about the care plan, and said, "My husband deals with the care plan." Everybody we spoke with felt that the staff knew people individually. One relative said, "They [staff] know her [relative] as a person it's not just a job."

We looked at a selection of care records, most of which were stored electronically. We found that care plans lacked information in some cases. For example, one person had a care plan in place regarding mobility and the use of a hoist to transfer. The care plan gave no instruction regarding the size or type of sling required or where the loops should be positioned for each transfer. We spoke with the registered manager about this who took appropriate action to address the situation.

Although documentation was not always completed in full, staff we spoke with were knowledgeable about people they provided support and care for. We observed appropriate interactions and people's need were safely addressed.

There was a mixed response to questions about the social activities available, with people living on the upper floors knowing little about them. Most people on the ground floor were positive about the level and quality of the activities a visitor said, "There is bingo, arts and crafts, old time music, and they are good." The majority felt that they could do what they liked during the day, one person said, "I have been out to the Golf Club for lunch a few times."

The provider has a complaints and compliments policy and we saw evidence that complaints were dealt with appropriately and within timescales; responses were made by the registered manager and the operations manager. There was evidence that the directors had considered lessons learnt from any complaints made. Nobody said they had made a formal complaint, but they were happy that they could raise issues and get positive responses, one visitor said, "I have no complaints, and if I had I would just go to the head of department."

People we spoke with knew how to raise a concern if they need to and felt they would be listened to. One person said, "I haven't wanted to complain, not since the first night anyway." Another person said, "I haven't got any complaints, I would just tell somebody."

People had access to advocacy information and details of this were displayed in the foyer. Details of activities were displayed throughout the home. There was a suggestion box in the foyer for use by people, staff and families. Some signs, for example, one about the refurbishment of the lounge were displayed in another language to support a person whose first language was not English.

Requires Improvement

Is the service well-led?

Our findings

At our inspection of July 2015 this domain was rated Good. At our inspection of April 2018, we found the registered provider had not identified all the concerns we identified. Audits and daily checks of the home, undertaken by the management team, had not always identified areas of improvement.

The registered manager completed daily checks of the home and had a daily meeting with unit managers. The registered manager submitted a weekly report to the area manager. This report included training compliance, recruitment, staffing hours, governance, maintenance and health and safety checks.

We saw quality audits took place each month and were reviewed by the registered manager and the area manager to measure progress. These audits looked at general areas as well as reviewing fire risk assessments, medication management, care records and outcomes monitoring for people, staffing, and health and safety. We saw some actions from these were cascaded to appropriate staff, for example, in team meeting minutes. Risk assessments for areas or tasks were detailed and kept securely. We saw these had been updated annually.

However, we found that these audits had not identified all the issues we raised as part of this inspection. For example, care records were not detailed and daily charts were not always completed. Also during a tour of the home we identified some minor issues with infection control. We also identified some unlabelled bottles containing fluid in use in the cleaning store and kitchen cupboards. It was not clear what was in them, the registered manager though they contained cleaning fluids, this posed a risk to people and had not been identified as part of the quality monitoring. We also found some minor concerns with the management of medicines. We also found people who required moving and handling using hoists and other equipment did not have detailed plans in place to ensure this was completed safely and following appropriate assessments.

We brought these issues to the attention of the registered manager, who took action. For example, following our inspection the registered manager informed us that people requiring the use of moving and handling equipment to transfer, now had a full detailed plan in place.

The registered manager also told us that the housekeeper was off work and this had impacted on some of the audits and was why some issues had not been identified. They acknowledged that this position needed to be covered until the housekeepers return to ensure the audits were completed.

We saw action plans in place which showed where maintenance, damage and repairs were logged and monitored. For example, there was a schedule of a rolling programme of redecoration to the home and bedrooms. There was a clear audit trail for these and records showed the registered manager monitored these regularly. For example, infection control audit had identified some areas requiring new flooring and this had been included in the maintenance action plan. However, there were some issues identified on inspection, which had not been identified. The registered manger was not able to explain why they had been missed but assured us the issues would be addressed.

We spoke with people who used the service and their relatives and they all felt the home was well managed. One visitor said, "It is well run but personalised, not regimented."

We spoke with people who used the service and their relatives about the management of the home. The majority of feedback we received was positive. One person said, "She [registered manager] is approachable, she has been in this morning to chat." There was a generally positive feeling about how the staff and management would respond to issues being raised outside of formal meetings. One relative said, "They would address any issues raised."

Everybody made positive comments about the atmosphere in the home. One relative said, "Warm, welcoming, safe and supportive." Everybody said that they would recommend it to others a visitor said, "I have recommended it already."

Although the service was registered to provide nursing care, the home did not provide nursing care and hadn't done for some years. We asked the registered manager to apply for this regulated activity to be removed if it was no longer being provided.

There was an open and supportive culture. People, staff and families were asked for their feedback through annual surveys, monthly staff meetings and bi-monthly 'residents and relatives' meetings. The registered provider kept everyone informed about how the service was developing by sharing minutes of these meetings and producing action plans as a result of these. A monthly newsletter is produced for people, staff and families containing information about people, activities and entertainment, training programme, changes in the home, and birthday wishes. The registered provider ensured any learning from complaints or experiences was shared across the organisation through team meetings.

The registered provider strived to continuously improve the service. The home was part of a NHS-led pilot to reduce falls and their impact on people. A falls flow-chart was used, falls and accidents were monitored, measures put in place to reduce the risk, and staff received additional training.

There was a 'future plans' folder which detailed refurbishment plans, including the lounge refurbishment and a rolling programme of bedroom redecoration and the replacement of old bath chairs.

As a result of the monthly quality audits a new training matrix had been developed and had meant training was monitored and planned.

There was evidence of community involvement, for example, local school children attend regularly for signing and a mindfulness colouring club. The local community were invited to the home's 'open day' and the home had links to other community activities such as Penistone Show and the Tour De Yorkshire. Church services were held in the home regularly and people were able to go on supported trips, for example, to the theatre or cinema.