Anchor Hanover Group

Buckingham Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Buckingham Lodge is a residential care home providing personal care to 36 people aged 65 and over at the time of the inspection. The service can support up to 64 people.

The care home is purpose built and accommodates people over three floors. Each unit has its own lounge, kitchenette, dining areas and bathroom. Alongside this the care home has a cinema room, hairdressers and family room. The ground floor unit provides care to people with dementia, whilst the first floor provides residential care. The second floor had a mix of people with residential and dementia care needs.

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

People and their relatives were generally happy with the care provided and described staff as kind and caring. They felt their family members health needs were met and told us how their family members overall health had improved. However. they told us there was a lack of continuity in care due to the high use of agency staff and there were limited activities provided.

We found risks to people were not mitigated which had the potential to put people and staff at risk. The service had a high number of staff vacancies. This led to inconsistent care for people and a lack of suitably skilled staff on shift to promote safe care. We have made a recommendation to address this. Systems were in place to safeguard people and their medicine was appropriately managed. The home was clean, and systems were in place to mitigate infection control risks. The provider monitored accident and incidents and picked up trends in accidents/ incidents to prevent reoccurrence.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however, the policies and systems in the service did not support this practice. We have made a recommendation to address this. Staff inductions and training took place. However, the provider had identified gaps in training and the completion of inductions and formal supervisions of staff which they were addressing. People were assessed prior to admission to the home. Their medical and nutritional needs were identified and met.

Person centred care was not consistently provided. People had care plans in place which were under review and development. They did not have access to regular in house or community activities. Their end of life preferences were not identified. Recommendations have been made for the provider to work in line with best practice to promote person centred care. Systems were in place to deal with concerns and complaints which enabled people to raise concerns about their care if they needed to.

People and their relatives confirmed staff were kind and caring. Their privacy and independence were promoted. We observed positive and negative interactions between staff and the people they supported. We have made a recommendation for staff practice to be monitored.

The service did not have a registered manager and there had been three registered managers since the service was registered with the Commission in 2015. This had led to inconsistences in the management of the service. A new manager had been appointed and was due to start the week after the inspection. The provider had systems in place to audit the service. They had identified shortfalls within the service and had an action plan in place to bring about improvements. However, the findings of this inspection demonstrated good governance was not established.

Rating at last inspection: The last rating for this service was good (published 18 January 2018). At this inspection the rating had changed to requires improvement.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Buckingham Lodge on our website at www.cqc.org.uk.

Why we inspected
The inspection was prompted in part by the increase in notifications of incidents between people and concerns we received about staffing levels, people's care and the management of the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see safe, effective, responsive, caring and well led sections of this full report.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Enforcement
We have identified a breach in relation to the management of risks and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Buckingham Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014. The inspection was brought forward from the planned return time due to the level of concern received by us. We were concerned about the level of safeguarding alerts made and had received whistle blowing information about staffing levels and the management of the service which we were told impacted on people's care.

Inspection team
On day one the inspection team consisted of one inspector, an assistant inspector and a specialist advisor (SPA). The SPA area of expertise was in the care of people living with dementia. On day two the same inspector visited the service with another inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
Buckingham lodge 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 required to have a registered manager. At the time of the inspection the service did not have a manager registered with the Care Quality Commission. A new manager had been appointed and was due to start on the 17 June 2019. The service was being supported by a regional manager.

Notice of inspection
This inspection was unannounced. Inspection site visit activity took place on 5 and 6 June 2019

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority and the Clinical Commissioning Group (CCG) who had recent involvement with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who used the service and four relatives about their experience of the care provided. We spoke with 14 members of staff including the district manager, regional manager, deputy manager, one team leader, seven care workers, head housekeeper, maintenance and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at records such as policies, staff rotas, training data and quality assurance records. We spoke with three relatives by telephone. We sought feedback from professionals who regularly visited the service, but none was received.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

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

Assessing risk, safety monitoring and management

● Risks to people were not always mitigated which had the potential to put them at risk. Risks associated with moving and handling, nutrition, falls, managing behaviours that challenged and medical conditions such as diabetes had been assessed. However, guidance to staff lacked detail around the actions and control measures in place to mitigate the risk.

● The service had people who presented with behaviours that challenged. There was no guidance to staff on how to prevent the challenging behaviours escalating.Staff gave different feedback on how they managed challenging behaviour situations. Some staff told us if a person became challenging whilst they were supporting them with personal care they would hold the person's hands. Other staff told us they continued with the personal care despite the escalation in behaviours that challenged, or they would leave the person and try again later. Staff confirmed this resulted in a delay in the person having their personal care needs met. We saw from the challenging behaviour records the challenging behaviours recorded had the potential to put the person and staff at risk of injury.

● A person's records showed they were deemed at high risk of falls. The falls risk assessment made reference to the risks associated with medicines the person was taking as opposed to how the risk of falls could be mitigated. The person had a recent fall and whilst the risk assessment was reviewed, and a referral was made to the fall's clinic, no further measures were put in place to mitigate the risks until the person was reviewed by the fall's clinic.

● The risk assessment for a person with diabetes made reference to hypo glycaemic and hyper glycaemic symptoms. Hypo glycaemic symptoms occur when blood sugars go too low. Hyper glycaemic symptoms occur when people with diabetes have too much sugar in their bloodstream. However, the risk assessment did not define the symptoms or what actions staff were to take in the event of a person developing those symptoms.

● During the inspection we observed staff had moved and handled a person into a chair and had not ensured the chair was steady. A staff member saw this and alerted other staff to it. The person was moved again so the chair could be steadied. We observed also the brakes on wheelchairs were not always applied prior to a moving and handling manoeuvre. The provider confirmed after the inspection they had increased the monitoring of staff to ensure safe care was provided.

● Regular tests were carried out on fire and lifting equipment. The provider had not taken action to ensure people were protected in the event of a fire. For example, the provider had identified that action was required to resolve a problem with emergency lighting in January 2019. This action was still outstanding at the time of our inspection.

● During the tour of the environment the laundry, pantry and staff room door was wedged open. These were all high-risk areas for a fire. The provider took immediate action to remove the wedges and put signs up on the doors to remind staff not to wedge them open.

We found reasonable steps had not been taken to mitigate risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed risk assessments were in the process of been updated and more specific to enable them to identify how risks would be mitigated.

● Environmental risks had been identified. Risk assessments had been written for the fire and water to ensure people were protected from avoidable harm.
● The provider had processes in place to carry out monthly health and safety checks. However, due to the absence of a registered manager these had not always been completed within the expected timescales. The regional manager told us they had commenced the monthly managers health and safety check in May 2019 and would ensure this was completed every month going forward.
●The information of concern we had received prior to the inspection indicated people were left in bed for a lengthy period of time as the home had no staff trained to carry out moving and handling assessments. We saw two staff had recently been trained to become moving and handling assessors and they were due to update staff on this training.

Staffing and recruitment
● Sufficient, experienced staff were not always provided on shift. People, relatives and staff told us the staffing levels were not sufficient and the high use of agency staff lead to inconsistent care for people. People commented "I am Ok but things are going downhill dreadfully. Lack of attention, hardly any care staff here". "Not enough staff and it is difficult to get help at times". "Not as good as it was. There is not enough staff. Due to being short staffed things are not getting done, like activities and people are bored". "Agency staff are here today and gone tomorrow". "Staff don't get to me quickly enough. There are times when I need the toilet and they don't get to me quick enough". "The home could do with more regular staff and fewer agency. You see lots of new faces and that can be worrying for those people with Dementia and the staff can't know us if they haven't been here before".
● Relatives told us the staffing levels did not seem sufficient and they worried that their family member did not always get the care and support they required. Relatives commented "I am very concerned that there are not enough staff". "There is a lack of staff and constant changes in staff. Nobody [staff] around when somebody needs help". "Staff fine here but they haven't got the time to interact with people on the floor. Don't always know what people want as they haven't got to know people". "There is not enough staff to coordinate everyone needs and care". A relative told us of a recent occasion where their family member's call bell went unanswered. This was fed back to the provider to investigate and act on.
● Staff told us that the staff to people ratio was poor and this led to little time to act to any great extent on a personal level with individuals. Staff commented "The turnover of staff is high which has had an impact upon the care given to people", "The agency staff do not know people and therefore the routine is often broken, and the personal bond is not as with permanent carers that know people". "Agency staff is used at present, who do not know people". "More staff would allow better personal care and for care not be so rushed".
● The service had a recent high turnover of staff and as a result used agency staff to cover the vacancies. They were actively trying to recruit into the vacancies. They had increased staffing levels on the ground floor but the lack of team leaders in post meant there was occasions where there was only one team leader on

duty as opposed to two.
● The provider had a dependency tool in place which was used to calculate staffing. Following the inspection the provider confirmed they had introduced daily and weekly checks of the rota to ensure appropriate staffing levels. They also advised they would be booking agency on a block basis of 4 weeks in advance, to ensure consistency.

It is recommended the provider keep the staffing levels under review to ensure they have suitably skilled staff available to meet people's needs.

● People were supported by staff who were recruited safely with appropriate pre-employment checks. These included references, checking identification, employment history and criminal records checks with the Disclosure and Barring Services. Any gaps in applicants' employment checks were checked as part of the recruitment process. None of the staff files viewed had a recent photograph on file. This was pointed out to the regional manager on day one of the inspection. On day two of the inspection the service had commenced taking photos of staff and adding them to their file. The provider had obtained confirmation from the agency of the pre-employment checks carried out for each individual agency staff member.

Using medicines safely
● Systems were in place to promote safe medicine practices. These systems were in line with national guidance and best practice. .
● Staff were trained and assessed as competent to administer medicines.
● The service had homely medicines in use which were agreed for individuals by their GP. These were signed by the GP. Some people were prescribed "as required" medicine such as pain relief or a tranquillizer. "As required" protocols were in place, which were signed by the team leaders. The protocols lacked specific detail as to when the "as required" medicines should be offered. The provider sent evidence after the inspection this had been addressed.
● People received their medicines as prescribed. Records of administration were accurately kept.
● People told us told us they got their medicines on time and that staff made sure that they had taken them. They commented" They bring in eye drops when they are supposed to. No problems at all with getting my medication". "Staff apply cream to my legs and bring in my tablets. It is always on time".

Systems and processes to safeguard people from the risk of abuse
● The provider had systems in place to safeguard people. Staff had access to the local authority safeguarding policy, procedures and the organisations guidance on safeguarding people. Information on safeguarding was displayed on notice boards in the home and accessible to people and their relatives.
● Staff were trained in safeguarding procedures and were aware of their responsibilities to report poor practice. Updates on safeguarding training was overdue for some staff. This had been identified by the provider and was being addressed. Staff members commented "Safeguarding is about making sure that people are safe and raising any concerns with management or the Commission". "Safeguarding and whistleblowing procedures help vulnerable people. I would raise concerns with my team leader if I felt something was not right".
● Senior staff of the organisation were aware of their responsibilities to report safeguarding incidents to the local authority and the Commission. Records were maintained of all alerts made. There are been an increase in safeguarding notifications. The provider had taken measures to address this by providing extra support for a person.
● People told us they felt safe. Comments provided included "Absolutely safe and secure, very homely. Staff are very helpful. They know me well". "Feel safe living here, I like the staff. If I have any worries I can talk to the staff. Quite happy living here".

● A relative told us of an incident involving their family member which had not been reported to the local authority safeguarding team. The regional manager had addressed that and made the required alert and CQC notification.

Preventing and controlling infection

● The premises were kept clean and hygienic. People were happy with the cleanliness of the home. They commented 'Very good housekeeping, they keep the place clean. All I do is ask and things are done". "Housekeeping incredible, good communication between them and us". "I appreciate the way the home is kept so beautifully".

● People were protected from the risk of infection. There were procedures and training for staff on infection prevention. Staff had access to and used disposable protective items, such as gloves and aprons. We observed that staff changed gloves before entering another bedroom.

● Audits were carried out to check staff followed good infection control practices. The kitchen was found to be clean and staff confirmed it was cleaned daily. However, there was no cleaning schedule in place. This was fed back and addressed during the inspection.

● The service had been awarded a rating of 5 (the highest rating) by the local authority, under the food hygiene rating scheme. This means hygiene standards are 'very good'.

Learning lessons when things go wrong

● The provider had systems in place to record accidents and incidents. Staff were aware on what they needed to report and record.

● Senior staff were responsible for reviewing and concluding incident records, including what lessons had been learnt. However, we observed this had not been completed in the timeframe expected by the provider. We spoke with the regional manager who confirmed they needed to close a number of records down. This issue had been picked up by an internal audit in October 2018.

● The provider had an internal newsletter which communicated important information including any learning across care homes.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff were not acting in accordance with the MCA 2005 or the provider's own policy. Some people's care plans included a MCA. The MCA was not decision specific. It only related to people requiring 24-hour care and it being in their best interest to live in the care home. Other people did not have a MCA but had a best interest decision on file. This was not in line with the MCA.
- Some staff confirmed they had received training in MCA/DoLS and had a good understanding of it. Other staff could not recall being trained in MCA/DoLS and had no understanding of how it related to the people they supported. Records showed the majority of staff had completed this training. However, our observation was that staff were not applying their learning in practice..
- The service had a number of people for whom DoLS applications had been made and people were supported in the least restrictive way.

It is recommended the provider works to best practice in line with the Mental Capacity Act 2005.

Staff support: induction, training, skills and experience

- Systems were in place to ensure staff were trained and supported. People and their relatives felt the permanent staff had the required skills and training, however, they felt the agency staff did not and it took time for new staff to get to know the job. A person commented "Carers are not trained to deal with someone

who is blind especially youngsters. It worries me, and they tend to avoid me because they don't know how to treat a blind person".

● Staff told us they had an induction which included e- learning, some face to face training and shadowing other experienced staff on shift. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme. Staff confirmed they were given the care certificate booklet but there was delay in these being worked through, completed and signed off. Records did not evidence that any staff member had completed the care certificate training. The provider had identified this and were looking at ways to try and address the back log with a group meeting planned to support staff on completing their care certificate.

● Staff had access to training which was considered mandatory by the provider. This included training in safeguarding, health and safety, infection control, food hygiene, fire safety and moving and handling. Staff had access to specialist training such as catheter care, pressure area care and dementia awareness training. The regional manager told us the dementia awareness training included training for staff on managing behaviours that challenged. The provider confirmed after the inspection they had requested further training on managing behaviours that challenged to support staff to have the skills to deal with challenging behaviour situations.

● After the inspection the provider send us evidence that bite size training had been arranged by them. This included training for team leaders and care staff on topics such as record keeping, emotional and psychological, including positive behaviour support plans and medicine and health needs care plans.

● Some staff told us they felt suitably trained and skilled to do their job. A staff member commented "There are a lot of different areas that we have been trained in and the quality of the training is ok". Other staff told us there was a delay in them receiving training in moving and handling. A staff member commented "Having such a high turnover of staff meant that any new staff (not agency) sometimes had to wait 6 weeks to be trained in moving and handling, and therefore they were not able to help with washing and moving if lifting was required, which put further pressure on the staff for personal care". The provider was aware of this. Two staff had recently been trained as moving and handling trainers and moving and handling training was scheduled.

● Some staff told us they felt supported, whilst other staff felt they were not properly supported. The majority of staff we spoke with could not recall when they had a formal one to one supervision. New staff could not recall having a probationary review and other staff who were longer in post could not recall having an annual appraisal. The provider had identified that supervisions of staff were not taking place. They had commenced these and had a schedule in place to get supervision of staff up to date.

Supporting people to eat and drink enough to maintain a balanced diet

● People's nutritional needs and risks were identified. Their care plans outlined the support they required with meals and the nutritional risks for individuals. People who were at risk of malnutrition were provided with meal supplements. Food and drink snacks were made available to people.

● We received mixed feedback on the quality of the meals. Some people were complimentary about the meals. They commented "There is always food and drink available". "The food comes fresh and it is nice". "Food on the whole is good,' "Always a choice but the kitchen will do different things, omelettes, jacket potatoes. I had a salad yesterday that I had asked for.' 'At the moment most of the food is lovely, meat is good, fish is good, puddings wonderful,'

● Some people told us the meals were not varied and commented "We always seem to get the same meal choices, no variety is provided". 'No quality to the food, can be cold, some food pretty awful,' Good plain food, good quality, choice of meals. Would like more variety in the meals, curry, pasta, A relative told us they thought the meals could be better. They commented "Meals could be improved on with better cuts of meat

provided." The provider was working with the newly appointed chef to bring about improvements to meals.

● The chef was aware of people's likes, dislikes and special requirements. A menu plan was in place which was made available to people and people were encouraged to feedback on the quality of the meals. The provider had recently instructed the chef and their team to be involved in serving the meals in line with Anchor's policy. This had commenced the week of the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were assessed prior to them moving to live at the home. The assessment document provided key information on people's needs, risks, communication and key people involved in their life's. It took into account people's skills, abilities, sexual orientation, cultural and religious needs.
● People and their relatives told us the manager or deputy manager had met with them prior to them coming to live at the home and they had the opportunity to look around it if they wanted to.

Staff working with other agencies to provide consistent, effective, timely care
● Each care plan included a transfer form. This was to be updated and sent with a person when they were transferred to hospital.
● Relatives told us they were informed of changes in their family member, although one relative told us there was a delay in them being informed their family member was admitted to hospital. This they told us was because staff rang them on their landline phone number rather than on the mobile which was the number the service had been informed to use. The provider was made aware of this to address it with staff.

Adapting service, design, decoration to meet people's needs
● The home was purpose built. It had wide accessible corridors and lots of seating areas throughout. The environment was dementia friendly. Each unit had a communal bathroom and kitchenette area.
● People told us that they liked their bedrooms. They commented "Lovely room, very lucky to have the view, can watch the birds. Love watching them". "Beautifully kept and furnished bedroom". "My bedroom is my home and I am very comfortable in it". However, there was some concern that the garden/outdoor space could be improved by having better grass maintenance and more flowers would help. A person commented "Garden is appalling, look at it. It needs looking after". The grass was looking overgrown and was due to be cut.
● The service had a planned works programme in place and access to a maintenance staff member, who was based at the home. There had been a leak in the kitchenette areas on the first and second floor. As a result, the skirting and plinths were removed. We were told this was to allow it to dry out fully. Areas of the home had paint damaged on the walls and on one unit the window blind was coming loose at one end. These were due to be addressed.

Supporting people to live healthier lives, access healthcare services and support
● People were supported with their healthcare needs. They had access to a range of health care professionals which included the GP, district nurses, dentist, opticians and podiatrist. People's records included a summary of the visit from the health professional, the outcome and follow up actions.
● People told me that they were supported, by staff, to attend the local GP surgery or hospital appointments if relatives were unable to take them. People commented "I have an eye appointment tomorrow. Usually my son takes me, at other times staff will arrange transport for me". "I seen the GP when I had a fall. Due to see him again next week". I have seen the GP when they come in on their rounds. I seen the chiropodist recently too".
● Relatives told us their family members health needs were met. Relatives commented "[Family member's name] health has drastically improved". "Mum's heath is much better now and living at the home has given

her a new lease of life".

● The service was working closely with the local authority and the Clinical Commissioning Groups (CCG) to improve communication between them and other health professionals such as the district nurses to ensure people got the right care and support.

● The service had a number of people with behaviours that challenged. There was no evidence that they had sought input or support from the community mental health team to better equip staff to manage those behaviours. The provider agreed to initiate contact.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always well treated and supported appropriately. During the inspection we observed positive and negative engagements. Staff provided people with reassurance, used appropriate touch and good eye contact when engaging with people. They sat next to them when supporting them with their meal. A staff member and a person using the service was observed sitting together, chatting and laughing. However, throughout the inspection staff used terms of endearment such as "sweetie and darling when addressing people. It was not recorded that this had been established that this was how people preferred to be addressed.
- Due to the staff vacancies the provider did not enable staff to have the time to be caring. This resulted in staff been rushed in their day to day practices and engagement with people.
- We observed some staff supported people with tasks such as eating their meal and hoisting them without any explanation or engagement with them about the task they were been supported with. Staff also engaged with other staff and people across the room as opposed to with the individual they were supporting with their care. We observed staff had little or no engagement with some people. One person came into the dining room at lunchtime. They were initially offered lunch which they declined. There was no further engagement with them for a period of 40 minutes. Another person was sitting at the table from 12.30 when they had their lunch and was still sat there at 16;00 hours with very limited engagement between them and staff.
- Staff told us that the homes' approach was caring and focused on the people they supported. A staff member commented "Due to the nature of people's condition (primarily dementia) the approach was "person centred care to allow choices", although due to lack of staff this was sometimes very difficult as pressure is on staff to complete daily tasks such as washing and dressing people."

It is recommended the provider monitors staff practice to promote best practice in caring for people.

- People and their relatives told us staff were kind and caring. People commented "All staff are very good, caring, kind and they do put up with an awful lot, they are nice staff." "Staff are very kind, never seen anything needing concern". "I can't tell you how lovely the carers are, they are very good, I find them caring and very helpful. They do ask if everything is alright and are you alright".
- Relatives commented "Staff are genuinely kind and caring", "The carers have a lot to deal with, but they always show kindness and compassion to my [family member's name]". "Staff are just brilliant, they work

very hard and support mum really well, as well as treatment her with great respect".

Supporting people to express their views and be involved in making decisions about their care

● People were given choices in everyday decisions such as meals and activities. Throughout the meal time we saw people were offered alternatives to what was on the menu. Some people were offered a choice of a hot or cold drink, whilst others were given a cold drink.

● We observed staff asking for peoples' permission before supporting them with a number of tasks including personal care and moving around the floor. People told us that staff asked them if it was alright to help, particularly with showering and personal hygiene tasks. A person commented "Staff never just do something, they always ask me first".

● Resident meetings took place, which was an opportunity for people to be involved in making decisions on activities and be informed of changes within the home. However, these were not established and were not taking place regularly. The provider confirmed they planned to have monthly resident meetings. We were sent the minutes of the meeting that had taken place in June and one was scheduled for July.

Respecting and promoting people's privacy, dignity and independence

● People's independence and privacy was promoted. People commented "I am very independent but somebody is always with me when I am having a shower. They do ask if it alright to do this". "Staff always ask before helping me. Staff have a good understanding that I can do most things independently but they keep an eye on me when I am in the shower". "All staff are interested in us, they know who can do things so encourage us to be independent". "I try to be as independent as possible. Keeping independent is important to me. Staff know that".

● People had their own bedrooms which were personalised. Throughout the inspection we observed staff knocking on doors and asking if it was alright to come in. We heard staff talking respectfully to people.

● A person commented "Everybody always knocks twice on my door and ask if it's alright to come in, even other residents knock on the door. Carers call me by my name. Can be private, lots of little rooms so can go there if I want privacy, also good when the family come, can be on our own. Staff do respect my space". Another person said, "Staff do ensure my privacy".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Requires improvement: This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Person centred care was not promoted. For example, care plans outlined that staff were to prompt, assist and support people with personal care. The care plan for a person on covert medicines did not outline how the covert medicine was to be given.
- The service had a number of people who displayed behaviours that challenged. Their care plans outlined the behaviours displayed but failed to provide specific guidance on how staff manage the challenging behaviours presented. Positive behaviour care plans were in place which highlighted the person likes/interests. These were used to distract and divert the person when they started to become agitated. However, the behaviour support plan failed to provide specific guidance to staff on what to do if the distraction techniques did not work and the behaviours escalated. A record was maintained of incidents of behaviours that challenged. This showed that for some people there was frequent episodes of behaviours that challenged, and the interventions carried out by staff did not prevent the behaviour escalating.
- After the inspection the provider sent us examples of care plans they had reviewed and updated which had taken account of our feedback. They had a plan in place to review and update all care plans to make them more person centred and specific.

It is recommended the provider works to best practice in developing personalised care plans.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had access to some activities, but they were not person centred, regular and did not enable people to access the community. Staff were responsible for facilitating in house activities. However, due to the number of staff vacancies staff, people who used the service and their relatives told us that regular, appropriate activities were not taking place.
- People told us they were bored and did not have enough to do. People said that they did not go out as much as they used to, and visits to garden centres and community centres had stopped. People commented "Activities were good then Anchor stopped activities. How care staff can fit in activities I haven't a clue". "Nothing going on, used to be when I first came here, carers have too much on to do activities as well". "I do get bored, nothing much to do".
- Relatives commented "No appropriate activities were offered to my [family members name], whom is anxious and tended to stay in their bedroom". "People sit around all day doing nothing but staring at the walls". "There appears to be no one in charge of activities and as a result activities do not happen daily".

● Staff members commented "More members of staff would be really useful, because we currently do not have time to undertake activities with people". "We often don`t have enough time to do the basic work on the unit, so I don`t know how we are to do activities as well".
● Some staff felt they did not have the skills or training to deliver activities to people with dementia who had limited communication and short-term concentration span. A staff member commented "The organisation have done away with the activity co-ordinator and we have been told "all people, all departments" are to take on the role. We have had no extra training to support us to do this".
● The organisation had a wellness coordinator who was supporting the staff to develop the activities. However, there was no flexibility in the rota to enable staff to have the time to provide a regular varied programme of activities.

It is recommended the provider ensures they provide regular opportunities for people to have access to person centred and a varied programme of activities.

● We saw evidence that activities were taking place that met some people's needs. People had completed activities which included making rice cakes with school children, making Easter bonnets, celebrating people's birthdays and exercise session called Oomph. Oomph is designed to promote physical and emotional well-being in people who live in care homes.
● People froma Christian faith background told us they regularly attended services organised by the local Baptist and C of E church communities. People commented "It is very important to me to go to services. Every third week Aylesbury ladies hold a service here". "They do have services here and I go when I can".

End of life care and support
● The service had one person who was receiving palliative care. Whilst their care plan referred to them receiving palliative care there was no end of life care plan or evidence that the service had explored the person's preferences, choices or spiritual needs in relation to their end of life care. The deputy manager told us that an end of life care plan would be put in place when the person's condition deteriorated.
● The provider had an end of life policy in place. It indicated people would lead and the service would support the individual to consider and plan for their death in their own time. It made reference to advance care planning. This was described as a discussion with either the person, and/or next of kin before their health deteriorates. The care plans viewed did not indicate advance care plans had been discussed or considered.

It is recommended the provider works to best practice and the organisations policy on end of life care to ensure people's preferences, choices, culture and spiritual needs are identified.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The provider had an Accessible Information policy which was due for review in October 2019.
● People's care plans outlined their communication needs and what support was needed. Visual flash cards were available to people who were unable to verbally express their needs.
● The provider was not meeting the accessible information standards for all people they supported. A person who was registered blind did not feel the service made any concessions to meet their needs. This was discussed with the provider who agreed to contact the Royal National Institute of Blind People (RNIB) to explore what aids/technology was available to the person.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy which reflected best practice on how to respond to concerns and complaints. This was displayed and accessible to people.

● People told us they would talk to staff or management if they had any concerns. A relative told us that under the previous management their complaint was not always acknowledged or dealt with appropriately. The provider was aware of this and had intervened to address the relatives concerns.

● The provider had a team who monitored complaints. They were called the customer relation team (CRT). Senior staff at Buckingham Lodge were prompted to investigate and conclude complaints in line with the provides timescale. We saw evidence where the CRT had asked for an update on a complaint made.

● In addition to formal complaints the service had a system in place to monitor comments made by people.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

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

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

- There was no registered manager in post. A regional manager was supporting the deputy manager to run the home. A new manager had been appointed and was due to start on the 17 June 2019. The service had three registered managers since it was registered with the Commission in April 2015 which had led to inconsistency in the management of the service.
- People told us there was no continuity in the management of the service. They commented "Managers change all the time. I would like the manager to come around and talk to us more". [Name of deputy manager] is so busy but is always helpful". "It would be nice if someone in authority came to chat and ask how things are". Relatives felt the service had not been appropriately managed. Some relatives told us the previous manager was not accessible or approachable. They felt communication between them and the home was generally poor. The provider was working to address shortfalls in the management of the service through an increase in their monitoring and having the regional manager support the service.
- The provider had a quality monitoring system in place. This consisted of a set of internal and external audits. However, these had not always been completed in line with the providers expectations. We looked at a number of audits completed. These included care plan audits and infection control. We noted actions had not always been recorded as completed.
- The provider arranged for an annual unannounced audit visit. The last visit was carried out on 5 October 2018. It concluded a rating of 84.32 percent. The audit identified the service could improve the way they managed incidents and accidents, care plan records and records relating to as required medicines, ensuring staff were provided with a one to one session with a line manager and update their training. Alongside this monthly provider visits took place which audited records, the environment, staffing and people's care. The provider had an action plan in place to address the shortfalls in the service and whilst improvements had been made there was still ongoing concerns and need for improvement in many aspects of practice.
- People's records were not suitably maintained. Some people had turning charts in place to mitigate the risk of developing pressure sores. Staff told us people were turned every two hours. The turning charts viewed indicated this was not happening with gaps of up to five hours recorded between some turns.Each person had a personal emergency evacuation plan (PEEP) to advise staff on how they needed to be supported in the event of a fire. One of the PEEP's viewed was not updated to reflect a change in a person's needs which meant they required two staff for moving and handling manoeuvres as opposed to one as was indicated on their PEEP. This was addressed during the inspection.

● People's care plans contained duplication of information and lacked specific detail on the care to be given. Care plans were meant to be reviewed monthly. Some were reviewed at that frequency and indicated no change. For example, one person's records showed there had been 26 separate identified "distressed behaviour records" completed since the 20 December 2018 but the reviews of the care plan failed to make reference to this and consider if other strategies were required to support the person. Other care plans were not reviewed at the required frequency.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Some people told us they had reviews of their care plans whilst others could not recall if that had taken place. Relative meetings were not taking place. A relative commented "There are no relative meetings, newsletters or email updates from the home to keep us updated". The provider confirmed they had two "meet the manager" dates scheduled for relatives to be introduced to the new manager.

● Staff meetings took place, but the provider recognised these were not at the frequency expected. A full team meeting was booked, and it was planned for those to be frequent and scheduled.

We found reasonable steps had not been taken to effectively assess and monitor the service and to ensure records were fit for purpose. This did not support high quality person centred care. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed audits, monitoring and records were being improved to ensure the delivery of high quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had systems in place to receive feedback from people. They captured people's feedback in a 'You said, we did' system and annual A folder of feedback was available in the foyer. We observed people had given feedback in January 2019 about the food, chair-based exercises and the state of repair of the car park. The provider had acted on these concerns.

● People, staff and relatives gave mixed feedback on the service. People told us the service is "A nice friendly place. Good atmosphere, staff seem to get on well with each other. When family come staff are welcoming". Another person commented "There is more to do, more management and more staff would make things better".

● Some staff felt the current interim management were supportive, engaging and approachable, whilst other staff felt management were not doing enough to retain and recruit suitable staff. Some staff felt the deputy manager had too many responsibilities and was not always supported. Some care staff felt the management did not support the care workers and one carer told us they felt "neglected and not supported". They told us "management do not help out on the unit, even though we are often short of staff". Some staff felt there was no team work and morale was low due to the high use of agency and pressure on the permanent staff team.

● The provider was committed to promoting a positive culture and had identified areas for improvement to enable them to achieve good outcomes for people. Their priority was to recruit, more staff and to develop them to have the skills to meet people's needs. They were looking at ways to improve communication and team work and had set up full team meetings and drop in sessions for staff to enable staff to share concerns with them to be addressed. The attendance at the staff drop in sessions was currently low but the provider hoped that this would improve over time.

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

● The provider had a duty of candour policy in place and they were aware of their responsibilities to be open and transparent when things went wrong,

● The provider was open and honest about the shortfalls in the service and was working to bring about improvements. They were receptive to feedback and proactive in making improvements.

Continuous learning and improving care

● The provider had an internal system called an 'Universal action plan', this was a live document which recorded actions from internal audits in one place. All senior staff had access to the document. The provider's representatives could also update the action plan. For instance, if a member of the provider's quality team visited they could add or complete an action.

● The provider was looking to re-introduce and train staff members as 'champions' for aspects of care such as dignity champion, activities, health and safety.

Working in partnership with others

● The service worked with the local authority and clinical commissioning group (CCG). Following safeguarding concerns raised the service had developed a safeguarding action plan which they had been sending to the LA and CCG with a copy to us each month. At this inspection we found some improvements had been made.

● The home was visited by the local school children, we saw photographs of people with the children it was clear from the expressions the sessions were enjoyed by both parties.

● The service supported local and national charities. They had recently celebrated Dementia action week in May 2019 and had held a Macmillan Coffee morning in September 2018. A care home open day was scheduled for the end of June. Relatives confirmed they had been invited.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not mitigated which had the potential to put people at risk of receiving unsafe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not fit for purpose and systems and processes were not established and operated effectively to ensure the delivery of high quality care.