Butts Croft Limited

Butts Croft House

Inspection report

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Tel: 01676540334

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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

This inspection took place on 20 January 2016 and was unannounced.

Butts Croft House provides care and accommodation for up to 35 people. The majority of people who live at the home are older people with dementia. The service also offers care and support to seven younger people with dementia. Younger people have a separate area for their accommodation however both older and younger people are able to access all parts of the home. Some bedrooms are double rooms. At the time of our visit, there were 25 people who lived at the home.

The home has 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.

The registered manager had worked at the home for six months. They were new to managing a care home, as well as new to working at Butts Croft House. The provider had not provided sufficient formal support to the manager to make clear what their roles and responsibilities were, and how to achieve these.

There was insufficient monitoring by the provider to ensure the accommodation people lived in was safe, and the staff delivered safe care. The provider had not sent us all of the required notifications.

We had concerns about the provider's fire safety checks and requested that Warwickshire Fire Authority undertake a fire safety check of the home. They visited the home on 27 January 2016 and identified a number of areas which required action.

People benefitted from a satisfactory living environment, although some areas of the home and some equipment was not clean. We considered some areas of the home a risk to people. We have asked the provider to act on our concerns.

Prior to our visit, concerns had been raised about the management of medicines in the home. The registered manager had acted on advice given by pharmacy professionals and most of the necessary improvements had been made.

Risks associated with people's care and support had been assessed, but more detailed guidance was needed to ensure people remained healthy and safe. There was no analysis or learning from accidents and incidents leaving a risk of further occurrences.

The registered manager and staff had limited knowledge about the Mental Capacity Act and when to take decisions in people's best interest. Deprivation of Liberty safeguards had been applied for.

People were cared for by staff who were kind and caring. There was a consistent staff group who knew people well. People did not have many opportunities to engage with staff, as staff mostly only had time to meet people's essential care needs such as personal care and support, and meals. People who lived with dementia did not routinely receive specific care tailored to meet the needs.

People were satisfied with the food provided and could have as much food and drink as they wanted.

People's care plans were not personalised to enable staff to provide individualised care to meet people's needs and in line with their wishes and preferences. Plans did not always detail people's skills in relation to tasks and what support they required from staff, in order that their independence was maintained. Staff had received dementia care training, but there were limited opportunities available to support people with their dementia care needs.

People were mostly supported to have access to health professionals when required.

We found a number of breaches 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 the report.

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 safe.

The provider had not carried out appropriate fire checks and we arranged for the fire authority to undertake a separate visit. Actions were required as a result of this. There were other concerns regarding safety of the premises. Risks to people's health and welfare had not been fully assessed to keep people safe. On the day of our visit, there were not enough staff to fully meet people's needs at all times. There had been concerns received about medicine management, but this was improving.

Is the service effective?

Requires Improvement

The service was mostly effective.

People were mostly supported by staff who had knowledge and experience to meet their needs. Staff had limited knowledge of the Mental Capacity Act and how to apply the principles of the Act to people who lived in the home. People were satisfied with the food and drink they received. They mostly had access to health and social care professionals when required.

Is the service caring?

Requires Improvement

The service was mostly caring.

On the day of our visit staff were kind, caring and considerate of people's privacy and dignity, although we were informed of occasions where privacy had not been respected. Care plans did not inform staff of people's individual wishes and preferences to support staff provide personalised care. Visitors were welcomed in the home at any time.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Many people who lived at the Butts Croft House lived with dementia. Staff did not have the time to provide support which met people's dementia care needs on a daily basis. The complaints policy and procedure was not robust.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not have adequate systems in place to support the registered manager in their role and responsibilities, and in ensuring the service provided safe and effective care to people. Staff, people and relatives thought there was a good atmosphere in the home, and staff turn-over was low. The individual responsibilities of the management team were not clear.

Butts Croft 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.

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This inspection took place on 20 January 2016 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who supported this inspection had personal experience of caring for someone who lived with dementia.

We reviewed information received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioners to find out their views of the service provided. These are people who contract care and support services paid for by the local authority. They had not received any concerns about the service.

We undertook general observations and formal observations of how staff treated and supported people throughout the service. 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.

During our visit we spoke with eight people who lived at Butts Croft, and five visitors. We spoke with six staff (care workers and domestic workers), the deputy manager and the registered manager. We also spoke with a visiting health care professional. We reviewed five people's care plans to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. We requested to look at other records related to people's care and

how the service operated including the service's quality assurance audits, safety records and records of complaints.

Requires Improvement

Is the service safe?

Our findings

We looked at the safety of the premises and equipment. We looked at fire records and saw there had been very few fire safety checks made in the last few months. No one at the home had designated responsibility to undertake fire safety checks on equipment, and the registered manager's knowledge of fire safety was limited. Fire safety audits had not been undertaken and the provider had not checked to ensure fire safety checks were being carried out.

We notified the fire service of our concerns and they decided to undertake their own separate inspection of the service, to determine how safe the home was. Shortly after our visit they carried out a Fire Safety Compliance Check, and found a number of areas where the provider was not compliant with fire safety regulations. They have given the provider a period of time to rectify non-compliance and they will be returning to the home.

We had other concerns in relation to the premises. We found one bedroom, which was accessed via a door from the lounge, did not have its own door. The person who lived in the room did not have privacy from the person using the room below them on the ground floor. The stairs which led up to the room were steep and narrow, and at the top of the stairs there was bannister which acted as a barrier between the bedroom and the stair case. The bannister was low and there was a potential risk of a person falling over the bannister and down the stairs. The room had recently become vacant, and the registered manager agreed not to use this room until it had been made safe and private for people's use.

We found the vinyl flooring in the reception area had come away from the surface of the floor but was not torn. It had raised a bubble which did not go down when trodden on. This had posed a trip hazard to people. A ramp had been constructed outside of the office. The edges had not been made smooth so it posed both a trip hazard and a risk to people who did not wear shoes (a number of people in the home were not wearing shoes when we visited). The edge of the ramp was not butted up to the wall because it crossed the office doorway. The gap posed a risk to people falling from the top of the ramp sideways through the office door. When we reviewed the accidents and incidents to people, we found in September 2015, one person had sustained an injury by falling this way. No action had been taken to reduce the risk of this being repeated.

We saw oil fired portable radiators were being used in some people's bedrooms. One person told us the heating system was not working so oil radiators had been put in the bedrooms which could get very hot. The registered manager confirmed they had been having problems with the heating and the water, and the portable radiators had been brought in to make sure people were kept warm. We were concerned that that the surface temperature of the radiators might pose a burn risk to people if they fell against them. There were no risk assessments in place to determine whether they might pose a risk in the rooms of people who were using them.

In two people's bedrooms there were exposed electrical wires which put people at risk of electrocution. In a communal bathroom, a frame used to support people when they sat on the toilet, was rusty and was an

infection control hazard because it could not be cleaned, and could also damage a person's skin if their skin brushed up against it.

We saw disused bed bases and mattresses were stored in people's rooms and in stair wells, and this was a fire risk. We asked the registered manager why this was the case, and they told us there was no storage space for them. Two days after our visit the registered manager contacted us to tell us they had disposed of the disused bed bases and the rubbish bags.

Whilst we saw cleaners cleaning people's bedrooms and bathrooms, we saw the communal lounge in the main part of the house was not clean with food debris on floor surfaces, furniture and mobility aids. We observed one person ate their dinner from an 'over-chair' table which was damaged. The washable surface had worn away and chip board was exposed. This was dirty and could not be cleaned effectively. The registered manager agreed to remove the table immediately. We asked one of the cleaners if there was a cleaning schedule for tasks that required undertaking less frequently, such as cleaning skirting boards. They said there was not one.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and Equipment.

Prior to our visit, we had received concerns from a pharmacist that medicines were not being managed safely. They told us that whilst no one had come to any harm, they were concerned that medicine practice might lead to harm if staff and management did not improve their ordering, disposal, recording, and checks that medicines had been given as prescribed. We contacted the local authority who were also aware of these concerns and had visited the home to support the registered manager in addressing the issues. The registered manager and deputy manager told us they had worked to improve the administration of medicines since these visits.

We asked people if they received their medicines when they needed them. One person told us, "They never forget to give it and make sure we take it." Another person told us medicines they had prescribed as 'when required' were given when needed, "If I am in pain and request pain killers, as long as enough time has passed (for safety) I would get more."

We checked a sample of medicine administration records. We saw records had been completed accurately, and recorded when medicines had been administered, and if not, the reasons why. For stronger medicines which required more safety checks, we saw two staff had signed to say medicines had been administered and the totals in stock were as identified in the record.

Medicines were being stored correctly and securely. We were told the temperature of where medicines were stored (the room or the fridge) were checked regularly, but on the day of our visit these checks could not be found.

Medicine plans were in place for medicines given as required (PRN). A couple of these plans were for people who might need pain relief but who could not verbally inform staff if they were in pain. The plans did not detail how the person might communicate they were in pain, and when to administer on an 'as required' basis. There was a risk staff would inconsistently administer this medicine. The registered manager contacted us after our visit to confirm they had rectified this.

The provider did not have a medicines policy. The registered manager and deputy manager told us there used to be one but it could not be found. This meant there was no written information for the registered

manager or staff about who was accountable and responsible for the administration of medicines in the home, how to administer medicines safely, and who and when to report any medicine errors under safeguarding. The registered manager was aware they needed a policy but told us they had not had time to put this in place.

On the day of our visit there were not enough staff to meet people's needs at busy times of the day. People and visitors we spoke with told us, "There is not enough staff", and, "There is staff but they are very scarce." Another person said, "It sometimes feels understaffed. I have seen care staff doing the cooking, so when they are on duty they are not necessarily dedicated to giving care."

On the day of our visit a care team leader was working in the kitchen as the cook had given short notice that they would be absent that day. This meant for 27 people, there were three care staff on duty instead of the four expected. The three care staff had to support a large number of people with high dependency needs, and with one staff member based in the younger adults section, this left two care staff supporting 19 people. The registered manager and the deputy manager helped to support people with their care needs. However we saw times during the day when people with high dependency needs, such as people who required support to help them move, were left without staff being available to help them if required. We were told there used to be five staff on duty in the morning, but this had been reduced as the number of people who lived in the home had decreased.

Written risk assessments did not always support staff in giving them a clear understanding of what to do to minimise risks and to ensure consistency in care. For example, a risk assessment for skin care, informed that the person was at high risk of having skin damage. There was no information for staff about what they should do to minimise the risk of this occurring. Another care record informed us that if a person got 'bored', they were at risk of leaving the building, and going to the other side of the road. The response to this risk was for staff to bring the person back to the home, and not look at how they could minimise this happening in the first place.

Staff told us they did not routinely read risk assessments and care plans. One member of staff said, "We speak to each other about how to care for people, what they need and how to support them. There are risk assessments and care plans but I don't think I have read them in the last month." Another member of staff said, "We know people really well, and how to support them in a safe way. There are care plans but to be honest I never have time to read them."

We looked at the accident and incident record. We saw in a six month period there had been 15 incidents where people had fallen, with one person falling five times. We found no falls analysis or risk reduction plan for this person so that actions could be considered about how to reduce the risk of them falling again. The registered manager confirmed this had not been done.

A visiting professional voiced concerns about people walking around the home with only socks on their feet. They told us they felt that, overall the home was safe, but their concerns were about people falling because the flooring was slippery and not many people wore footwear.

People told us they felt safe at Butts Croft House. One said, I feel safer now than I have felt for a long time, there are people around me and look after me at night." Another said, "I feel safe here, it is like a home from home."

Staff understood the types of abuse and their responsibility to report any concerns they had to keep people safe. They knew how they would respond to any allegations or incidents of abuse. For example, we gave

staff a safeguarding scenario to check their understanding. One member of staff told us, "I would go to the manager because nobody should be treated like that, I would be pretty disgusted that would happen." Another member of staff told us, "I have had training in safeguarding people from harm, and would report any concerns I had to the manager or deputy manager. There is a phone number we can call to contact the local safeguarding team."

We had not received any safeguarding notifications from the provider, and the registered manager confirmed there had been none. The local authority had not been alerted of any safeguarding concerns from Butts Croft House.

Requires Improvement

Is the service effective?

Our findings

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.

We checked whether the provider was working within the principles of the MCA. We saw one person requested a cigarette many times during our visit. We saw negotiations as to when the person could have their cigarette, for example, "If you do this, then we will get you your cigarettes." The registered manager told us the person lived with dementia and if the cigarettes were not withheld, they would be smoked very quickly. The person's capacity had not been assessed to determine whether could understand the implications of smoking cigarettes one after the other, and the record showed no information about how the decision had been reached to ration the number of cigarettes given to them. We did not know whether the person had consented to this practice, or, how this was in their 'best interest', and whether it was the least restrictive option to the person's rights and freedom.

Another person was due to attend a local clinic for a health investigation. The deputy manager told us, "The person hasn't been asked for consent and I don't think they would understand the procedure." They confirmed no capacity assessment had been made to determine whether the person would understand the decision, and no 'best interest' decision making procedure had been followed or documented.

Staff had limited understanding of the MCA. One staff member told us, "I haven't done any training in the MCA, I don't know if people here could consent to their care." Another member of staff told us, "I don't know about the MCA, I think managers ask relatives for permission to do things." Although staff did not know the principles of the MCA, they mostly sought consent from people who they supported. A person told us, "They always ask my permission to do personal care." Staff knew they could not undertake a task if a person refused, for example a member of staff told us, "I would never do something against someone's will. I would always explain what we're going to do." However we saw an example of a member of staff limiting a person's freedom to do what they wanted. One person was walking around the lounge and staff told them to sit down and told them where to sit. The person was not given a choice or asked if they would like to sit down or where they would like to sit.

The provider was in breach of Regulation 11: Need for consent. Health and Social Care Act 2008 (Regulated Activities), Regulations 2014.

The registered manager and deputy manager understood their legal responsibilities to apply for Deprivation of Liberty Safeguards for people who did not have capacity and whose freedom of movement had been restricted. DoLS applications had been made to the local authority. Some had been agreed and were in the process of being renewed.

People received support from staff who had appropriate skills and knowledge to meet their personal care needs. A relative told us, "[Person] is well cared for, the staff know how to meet their needs." A person told us, "I think the staff know how to look after me, I have my ups and downs and they know how to deal with me."

Staff had completed an induction programme which included training the provider considered essential to meet people's health and social care needs. Staff told us they had received support from experienced staff in the service which had allowed them to get to know people and understand their role and responsibilities.

Two staff members told us they had received training to help them understand what it was like for people who lived with dementia; both thought it had helped their knowledge and understanding. Staff also told us they had undertaken national vocational qualifications in care and these had helped with their knowledge relating to care.

Staff had not received regular formal supervision with the registered manager. This would have given staff the opportunity to meet with their manager to discuss their learning and development needs and any other issues in relation to their work. The registered manager acknowledged they had not met with staff on a one to one basis to discuss their work as regularly as they would like. They were hoping that now they were more established in post these would increase. They assured us that they spent time working alongside staff on a daily basis and were able to observe how staff supported people and would address any concerns if they arose.

People told us the meals they received met their needs. One person told us, "The food is okay, sometimes not so good. I didn't eat properly before I came here. Sometimes the food is not enough but I can ask for more." Another person said, "I can't eat certain things but they make sure my diet is alright."

We saw people had a choice of breakfasts. Staff told us people could have what they wanted to eat. Choices included poached eggs on toast, bacon sandwiches, cereals, toast and porridge. We saw a person ask for a bacon sandwich and one was made for them. A member of staff told us there was no time restriction for people to have their breakfast.

There was no planned weekly or monthly menu; staff decided on a daily basis what food choices people would have. We were concerned there was no analysis of nutritional content of meals over the course of the week or month to check people had been offered a varied and nutritious diet. The registered manager told us they was in the process of planning menus.

Staff told us people had a choice of meals and on the day of our visit they had the choice of mash, pie, vegetables and gravy; or ham, chips, peas and homemade mushroom cheese sauce. But no choice was offered for two people who had their meals in bed. We asked staff why they did not have a choice. Staff told us, "We know what [the person] likes, we don't need to ask them."

During meal times people were supported to eat their meals where needed. Staff took the opportunity to engage in conversation with people whilst supporting them to eat. People were not hurried and could finish their meals at their own pace. People who required a soft food diet had this presented so they could distinguish the different textures and flavours.

On the day of our visit we observed people were offered hot and cold drinks frequently throughout the day. We saw one person had their drink thickened because they had a swallowing disorder and this reduced the risk of them choking. We spoke to a member of staff about the thickeners, they explained to us, "I think they

are meant to have it in all their drinks but the person prefers their tea without them." There was no care plan available to provide instructions for staff on how and when to use them. We looked at the container and found the thickener had been opened in early October 2015, and instructions on the container stated the contents should be disposed of after eight weeks of opening. It was still being used after 12 weeks. The scoop which measured the contents was dirty and caked in a layer of thickener. On the day of our visit records were not available to inform us that the speech and language therapist (SALT) had recommended the thickening agent, however a few days after our visit, the registered manager confirmed that the SALT had visited the person in October, and the person had thickened fluids since April 2015.

People mostly received support to have their health and social care needs met in a timely way. A person told us, "My leg is getting better since being here, they change my bandages twice a day and they know how to look after me." A visiting health care professional told us "Care staff are good at following instructions for people's health care." We saw that people had been referred to the speech and language therapists and GP when necessary. However, one person told us they had been in pain with their teeth and it had taken a while before a dental appointment came through. We looked at the records and found it had taken eight days for the person to see a dentist after records demonstrated they had complained of pain each day. Another person told us they wanted to go and see the dentist, but still did not have an appointment arranged. They said, "I have been waiting weeks for them to follow up a dentist appointment."

Requires Improvement

Is the service caring?

Our findings

Staff understood the physical care needs of people and had, from talking with people, gained some insight into people's likes and dislikes. For example, we saw some people were referred to by their first name, and others were referred to more formally, as preferred. However, care plans focused on people's physical needs and there was limited information about people's social needs, preferences and personal histories. For example, we saw four people walking around with socks on their feet and no slippers or shoes. We also saw four ladies wearing skirts or dresses with no tights, stockings or socks, but they had slippers on their feet. We could not determine if this was their preference as there was no information in their care file to inform us of this. One person told us, "I don't think staff know about my likes and dislikes."

The registered manager agreed care plans did not give enough information about people's preferences. They told us they were in the process of improving care plans. They were also introducing life histories to give staff more understanding of people's history prior to living at Butts Croft House, so that care could be planned with this in mind.

Relatives and people knew about care plans and most told us they had been involved in making decisions and planning their care. One person said, "I know about my care plan and they constantly re-assess me." Another person said, "I remember my care plan and I know I've been involved in it." A relative confirmed their family member was involved with the person's care planning.

People and most relatives told us staff were kind and caring. One person told us, "The staff are very caring and friendly," and a relative told us, "The staff are brilliant, they are really caring and kind." One relative told us they thought the standard of care was, "Below standard." Throughout our visit staff were kind and considerate to people's needs and there was friendly banter with some of the people who lived at the home. We heard a member of staff try to find out why a person seemed sad, they told the person, "If you're unhappy I'm unhappy, can you tell me why you are unhappy?"

Staff did not have a lot of time to sit and talk to people, but when they did, they listened and responded to people's views and opinions.

People's needs were responded to in a timely way. For example, at lunch time one person got up from the table. They were discreetly asked if they wanted to go to the bathroom and if they would like assistance. People told us when they used the call bells it did not take long for staff to respond. A person told us, "When I feel unwell or uncomfortable and press my buzzer, they don't take long to come." Another person told us that staff took longer to respond at night time but they did not say this left them feeling in any discomfort or distress.

People told us staff were polite and treated them with respect. One person said, "Staff always say please and thank you." Another told us they had a physical condition which they felt embarrassed about, but that staff, "Look after me, they know what they are doing."

On the day of our visit we saw people's privacy was upheld. One person told us, "I can go to my room when I want to be private." Bedroom doors were shut when personal care was being provided to people to ensure people's privacy. A relative told us, "I have waited outside my relative's room whilst they have been providing care and they have not known I am there. They are kind and caring at all times." However another relative told us they had recently seen a person being showered with the door open. Another relative told us that they had put curtains up in the person's bathroom because it was "not private" and was on the ground floor. They were concerned that people could see personal care being provided in the bathroom.

People told us their friends and relatives could visit at any time. During our visit we saw relatives visited people and stayed for as long as they wanted.

Requires Improvement

Is the service responsive?

Our findings

We saw people could move freely around the home, and were independent to decide when they wanted to be in their own bedrooms and when they wanted to be with other people. However, we did not see staff having the time to undertake activities with people on a day to day basis which might promote independence. Care plan information lacked detail and so we could not determine from plans what people's strengths were, and how independent they could be.

The service had a specialist unit for younger people with dementia and dementia related conditions, and many of the older people at the home also lived with dementia. Younger people were able to engage in some activities as they had more mobility. We found the manager responded to one person's needs to get out of the home, by taking them in the car when they went shopping. A person also told us they sometimes went on walks with staff.

Some people told us there were activities, but others told us they were 'bored' and there was nothing to do. At our previous inspection we saw many activities provided to people on an individual basis. The registered manager informed us that the activities worker no longer worked at the home and they had been trying to recruit staff to fill the vacancy but had not been able to do so. They were continuing to try to fill this post.

People who were unable to move around independently had little to do to keep them occupied and engaged. On the day of our visit we saw people were supported out of bed, and into the lounge. They then sat in their chair and ate their meals. We saw very little other stimulation as staff were too busy doing other tasks to engage fully with them.

Whilst staff had received some training in dementia, we did not see staff effectively use their knowledge to respond to people who lived with dementia. For example, a person was walking around in the communal lounge, instead of finding out why the person might be doing this and responding to this, they were told to sit down. We saw no reminiscence activities to support people with dementia.

People told us they had not made any complaints. For example, one person said, "I have no concerns, and no complaints. If I did I would speak to the senior staff." Another person told us, "I have no concerns, I have nothing to complain about." However, a relative told us they had written to the registered manager, making a formal complaint, and they had not received a response. The registered manager told us they had not received this, and would speak with the relative to make sure the complaint was investigated.

The registered manager informed us there had been no other formal complaints received. They told us there had been informal complaints but these had not been logged. The registered manager agreed it would be useful to log informal complaints to identify any trends or patterns in concerns raised, so they could be acted on.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post at Butts Croft House. They had worked at the home for six months prior to this inspection. They told us this was their first managerial post. The provider had not put in place any formal mechanisms to support the new manager in understanding their roles and responsibilities and to monitor their progress in achieving their responsibilities.

The registered manager told us the provider regularly visited the home. However we did not see any oversight by the provider to ensure the home was complying with the Regulations, and with Health and Safety legislation. At the time of our inspection the provider had been away for an extended period of time; however the registered manager told us they could contact them if necessary.

There were no checks to ensure all aspects of care were provided safely. For example, medicine audits had not been undertaken and this had led to concerns in relation to the administration of medicines, there were no falls audits, infection control audits, health and safety audits, or audits of care plans to ensure all the relevant information was contained in them. Risks which had been identified through accident reporting, and through risk assessments, had not been acted on to minimise or remove them. Significant risks in relation to fire safety had not been identified.

CCTV was used to monitor the grounds of the home, and also an area within the home near the manager's office. This area was used as a lounge area. There were no signs to inform people that CCTV was being used here. The registered manager told us there had been a sign to inform people that CCTV was being used, but a person who lived at the home had taken it down. They agreed they required a sign to inform people of the cameras, and said they would do this straight away. It was not clear why surveillance was taking place within this area of the home, and how it was in the best interest of people who lived there.

This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had notified us when people who lived at the home had passed away. However they had not sent us other notifications they are required to tell us about , for example when people had been admitted to hospital or if there had been any safeguarding incidents. This is important because it helps us to analyse whether there are any events or trends which might mean people have been put at risk. The registered manager told us they were not aware they needed to do this, and said they would ensure they notified us of these in the future.

The registered manager had a deputy manager and team leaders to support them with leadership of the home. This team were committed to providing good care to people who lived at Butts Croft. People and relatives told us, "The atmosphere is pleasant and happy", and "I have never heard arguments between staff at any time, there is harmony here." There was also very little staff turnover, which promoted continuity of care for people who lived there. One relative told us, "The staff are excellent, there is no worrying turnover of staff."

During our visit we saw good relationships between staff and the management team. Care workers felt able to express their opinions to the registered manager. One care worker told us, "I like the new manager, she's really nice; I can approach her about work and non -work purposes." Whilst staff liked the registered manager, they were not clear about what the responsibilities of the registered manager were, and what the responsibilities of the deputy manager were. For example, one member of staff told us, "There is a lovely atmosphere and I like working here. I don't think leadership is clear." Another said, "I am not clear who I would go to as I'm not sure of their responsibilities. I would probably go to either of them."

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 11 HSCA RA Regulations 2014 Need for consent Reg.11 (1) The provider did not have clear procedures to determine whether people had capacity to understand the risks relating to their behaviour. Where people lacked capacity the provider did not clearly demonstrate how decisions had been taken in their best interest. Reg.11 (2) The provider did not ensure that staff understood the principles of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Reg.15 (1) (a) The provider did not operate a cleaning schedule, or cleaning audit to ensure all areas of the home were cleaned, and the cleanliness of the home was monitored. Reg. 15 (1) (c) There were areas of the home, and equipment, which put people at risk. Reg. 15 (1)(d) The provider did not meet the requirements of fire safety legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Reg. 17 (2)(a) The provider did not have systems and processes such as regular audits to check they were meeting their legislative requirements, and ensure the quality and safety of the service. Reg.17 (2)(b) Identified risks to people had not

been acted on to minimise the risks in the future.