The Elms Residential Home Limited

Butterhill House

Inspection report

Coppenhall
Stafford
Staffordshire
ST18 9BU

Tel: 01785780380

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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 26 April 2016 and was unannounced. At our last inspection in March 2015 regulatory breaches were identified and the service was judged to be requiring improvement. The breaches were in relation to the safe care and treatment of people, safeguarding people from abuse and improper treatment and treating people with dignity and respect. At this inspection we found some improvements had been made but more action was needed to ensure medication was administered and stored safely and people were not being deprived of their liberty unlawfully.

Butterhill House provides support and care for up to 28 people, some of whom may be living with dementia. At the time of this inspection 20 people used the service.

The service had a registered manager. However, the person currently named on our register was not the same person who was now managing the service. 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.

Informal arrangements had been made to support people with their medicines if they needed them at night, however more formal arrangements were needed. Improvements were required to ensure the safe storage and administration of medicines.

The principles of the Mental Capacity Act 2005 were not consistently followed. People were at risk of unlawful deprivation. Referrals for a Deprivation of Liberty Safeguards assessment had not been made for some people who lacked capacity to consent to their care and treatment within the service.

Risks to people's health and wellbeing were identified and assessed but records were not always made with how to mitigate the risk. Action was not always taken to ensure people's risk of harm was reduced.

Care staffing levels during the day were sufficient to meet the needs of people who used the service. Improvements were needed to make sure there were enough night staff available so that people were safe and had their support needs met in a timely way.

Limited leisure and social activities were provided for some people, but not all people got the support they needed to engage in any meaningful activity.

People generally told us they enjoyed the food and had enough to eat. Not all records for the purpose of monitoring people's fluid intake had been fully completed to ensure people's needs were fully met.

The provider had a system in place to assess, monitor and improve the quality of care. However improvements were needed to ensure a consistent approach to improving the service.

Staff were aware of the safeguarding procedures and knew where and to whom they could raise concerns.

The provider had a complaints procedure and some people knew how and who to complain to.

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 consistently safe. People were not always able to have their prescribed medication due to a lack of suitably trained staff. People's risk of harm was assessed but action was not always taken to minimise the identified risk. People reported there were enough staff during the day but there were occasions at night when staff would be unable to support people in a timely way.

Is the service effective?

Requires Improvement

The service was not consistently effective. The principles of the MCA and DoLS were not consistently followed to ensure that people's rights were respected. Some people were offered choice of food, some people were not. Peoples' hydration needs were not always effectively monitored. Staff training needs had been identified with arrangements in place to provide training.

Is the service caring?

Requires Improvement

The service was not consistently caring as we saw some staff working practices were not as caring as they should have been. People's dignity and privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Limited recreational and leisure activities were sometimes available. However further improvements were needed to ensure these met everyone's individual needs. There was a complaints procedure and some people knew how to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not well led. The new manager had begun to implement quality monitoring systems. Further improvements were required to ensure that the health, safety and wellbeing of people were met. Staff told us they liked and felt supported by the new manager.

Butterhill 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

The inspection took place on 26 April 2016 and was unannounced.

The inspection team consisted of one 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.

We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with six people who used the service; they were able to tell us their experiences with the service. We spoke with other people but due to their communication needs they were unable to provide us with detailed information about their care. We spoke with two relatives of people who used the service to gain feedback about the quality of care. We spoke with the manager, the registered provider, three care staff and two visiting health care professionals. We looked at four people's care records, staff rosters, two staff recruitment files and the quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2015 the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. This was in relation to the lack of information for the use of occasional medicines and people were not able to receive their medicines during the night if this was needed due to staff not being adequately trained. At this inspection we saw that protocols and instructions for the administration of occasional medicines were available for staff to refer to. The provider told us that currently on Monday, Tuesday and Wednesday of each week night staff rostered on duty were still unable to administer medicines to people at night as they had not received the training to do so. We saw that some people had been prescribed as required medicines that they could have when they needed them and not at regular intervals. The provider explained the care staff who lived at the service and slept on the premises had been trained and would be available to support the night staff. However we saw no formal arrangements were in place for these care staff to support the waking night staff. People who used the service may experience delays in receiving their medication in a timely way because staff would have to dress and prepare themselves sufficiently to administer medicines. No risk assessments had been completed to consider the risk of increased medication errors that may occur when sleeping staff were woken.

Some medicines required cool storage to ensure they were safe to use and a medicines refrigerator had been provided. We saw that some medicines were stored in the fridge. Staff told us the temperature of the medicine refrigerator should be monitored daily when it is in use, and recorded. A maximum/minimum thermometer is recommended for this. We saw multiple gaps on the recording chart where this instruction had not been completed and there was no record of the minimum/maximum temperature. This meant there was no guarantee that the medicines in the refrigerator had been stored consistently within the required temperature range.

Some people had been prescribed medicines that had specific instructions when they were to be taken. A member of staff told us how the medicine should be given but was unable to verify if the instructions were being adhered to. There was no indication of the time when the medicine was offered to the person. No record was made on the medication administration record. This meant the person was at risk of harm as there was no guarantee that medicines were being administered as prescribed.

This was a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

The manager told us that presently the levels of staff were sufficient to meet the needs of the people who used the service. We saw that two care staff were allocated for the night shift. A member of staff explained that some people who used the service had high dependency needs and as such required two staff to support them with their hygiene and personal care needs. This meant there were occasions when the two night staff supported people with high dependency needs, other people would be unsupervised and staff unavailable. The provider told us that accommodation was provided for some care staff and as such when they were off duty they would be available to support the waking night staff if this was needed. However we

saw no formal arrangements were in place for these care staff to support the waking night staff.

Risks to people were assessed and plans were put in place when risks were identified. Some people had been provided with special mattresses on their beds to support them with reducing the risk of developing sore skin. We saw one mattress on a person's bed that had deflated and would not be effective in supporting the person with their skin care needs. We saw records were completed daily that indicated the mattress had been checked and was in good condition. The person's tissue viability care plan did not include any reference for this specific mattress in use and the actions needed to ensure it remained fit for purpose. We brought this to the attention of the manager who arranged for the care plan, risk assessment and daily checklist to be reviewed. A member of staff was instructed to check all similar mattresses in use, to make sure they were sufficiently inflated so they were effective and safe.

We saw people had been provided with walking frames to support them with moving around safely. Staff told us and we saw that risk assessments were completed when a person had mobility problems and was at risk of falling. The action needed to support the person with their mobility in a safe way was recorded.

Staff told us that on occasions some people would be resistive to receiving the support they needed with their hygiene and personal care needs. One member of care staff told us how they supported a person during these periods of anxiety. They told us they would leave the person for a short while and then return and try to provide the support the person required. We looked at the care plan for one person there was a record of the difficulties the person sometime experienced and the actions staff needed to take to support the person safely and effectively.

People told us they felt safe, secure and comfortable at the service. One person who used the service said: "I've been here many years. It's fine. I feel safe here and all my belongings are safe. I've got a small bedroom but it's very nice". A visitor told us: "I feel my relative is safe here. There always seems to be carers around to help when needed. The staff I have seen all seem to have a good attitude". We saw the day staff were generally available in the communal areas and so were accessible to provide help and support when this was needed.

Staff explained how they would recognise and report abuse. One staff member explained the procedures they would follow if they witnessed any abusive situations. They told us: "I would report any concerns immediately to the manager who would then take any action that was needed". The manager told us they had displayed the contact details of the relevant authorities and the action needed to be taken by staff if they became aware of any safeguarding concerns. We saw that notices with this information were prominently displayed in areas around the service.

We looked at the way the provider recruited new staff. We saw that at the point of employing the person all relevant safety checks had been carried out. References and Disclosure and Barring (DBS) checks were completed to ensure that prospective staff were of good character. The DBS is a national agency that keeps records of criminal convictions and helps employers make safer recruitment decisions and prevent unsuitable people from working with people in their own homes. Staff confirmed that checks had taken place prior to starting work at the service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2015 the provider was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014. This was in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were at risk of having their liberty deprived as the provider had not followed the principles of the MCA and ensure decisions were made in people's best interests. 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. At this inspection the manager told us referrals for three people had been completed and sent to the local authority for authorisation to legally deprive people of their liberty. They had received an authorisation to legally restrict the liberty of one person and were waiting for the other two authorisations to be granted. We saw some people who were unable to consent to some restrictions we saw in place, for example some people were not free to leave the premises alone and some people required constant monitoring and observation. The manager told us they were in the process of completing referrals for the people who lacked capacity to make specific decisions and had their liberty restricted.

One person who used the service told us that staff entered their room when they were out and removed some personal belongings without their consent or permission. They told us: "They [the staff] search my room; they must do it when I'm out, they don't tell me but I know they've been in because my belongings have gone. I then see it on the shelf in the office". We looked at the person's care records and saw an assessment had been completed which indicated the person had capacity to make decisions. There was no recorded information that the person consented to their room being searched, that it was in their best interest or in the least restrictive way. The manager told us the reasons for the staffs' course of action; they had identified this as being in breach of the person's human rights and had contacted the community psychiatric nurse (CPN) services for guidance and support. A meeting with the CPN and the person had been arranged to discuss and agree a course of action. However at the time of this inspection the consent had not been sought from the person for the action staff were taking.

These issues are a continuing breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us they enjoyed the food and had plenty to eat. One person who used the service told us: "The food is usually good. The cook decides the meals. Usually we have a choice of two main courses and a dessert. We have a hot drink about 11.00am and again at 3.00pm, I don't know if I can have an extra hot drink". Staff told us and we saw that people were provided with additional drinks when they requested one. Staff told us that some people needed to have their fluid intake monitored each day. We looked at a person's nutritional risk assessment and care plan who had their fluids monitored daily, there was no indication in the records of the person's target fluid intake. The monitoring records were saw were not totalled at the end of the 24 hour period so it was not possible to ascertain the person had sufficient for their needs.

People were encouraged to use the dining room for meals; however we saw that some people preferred to have their meals in their rooms. The meals were served from a hot trolley, some people were offered a

choice but for some people the meal was placed in front of them. Some people required support with eating their meal; we saw staff patiently helped them.

People were supported with their health care needs when this was identified. People had consultations with their doctor when they were unwell. A person who used the service said: "If you ask you can see the doctor and the chiropodist". A visiting health professional told us: "The staff really listen to what I say, I have no concerns, staff call me when needed". Other professionals such as the chiropodist, physiotherapist, district nurse and community psychiatric nurse were contacted when needed.

Staff told us they had training in various subjects for example moving and handling, infection control, fire safety and safeguarding people from abuse. Some people required mechanical equipment to support them with standing and transferring from area to area. We saw that staff were skilled and experienced with the use of the mechanical hoist and put people at ease when being supported with transferring. The manager told us the provider had agreed to obtain training packs from an outside source to ensure staff had the latest and up to date training they needed. The manager had identified that an up to date training planner was needed to ensure they were aware of what training staff required, what had been completed and when updates and refreshers were needed.

Requires Improvement

Is the service caring?

Our findings

We saw varied interactions between people and staff, some that were caring and some that were not as caring. For example, a person who used the service told us they had a sore throat. A member of care staff overheard the conversation and asked the person how they were feeling. The person was offered and provided with a bowl of ice cream to help the sore throat. The person commented this had 'helped a lot'. However we saw some incidences which were not so kind and caring. For example a person was given an inhaler to use whilst in the middle of eating their lunch and another person was given their medication to take, without being, an explanation of what the medicine was for.

One person who used the service for a period of time told us: "I'm not involved with my care plan and have not been asked". We saw very little input from the person or their representatives in the care plans we looked at. The manager told us they were currently reviewing people's care plans and had requested support from people's representatives.

People who were able to tell us their experiences were positive about the care and support they received from the staff. One person who used the service said: "The staff are brilliant, they are fantastic. Sometimes they seem to have a lot of work, too much to do, not enough time but I'm happy here". Another person said: "We get looked after very well. It's jolly good here, they keep you clean". We saw staff were attentive when supporting people throughout the day with their care needs. However, some people were offered very little choice in making decisions about their daily lives, some people were not offered choices at lunch time or what activities they would like to do.

We saw staff supported a person to transfer using the hoist, their dignity and modesty was preserved as staff ensured the person's legs were well covered whilst they were in the sling. One person who used the service told us: "The staff speak to me properly". For the majority of the time we observed people's privacy and dignity was upheld.

A visitor told us they could visit at any time and there were no restrictions. A person who used the service told us: "It is open visiting, my family can visit at any time. I go home to family for lunch every Sunday. It's good I can go out when I want". Another person said: "My family visit when they can". We saw staff greeted the visitors in a friendly way and made them welcome.

Requires Improvement

Is the service responsive?

Our findings

There were limited opportunities for people to engage in hobbies and activities of their choice. One person who used the service told us: "There is nothing to do, I don't have any hobbies". During the morning we saw there was no structured activity arranged for people to enjoy. People sat in one of the three lounge areas either watching morning television, sleeping or watching the activity within the service.

The activity board in dining room listed various activities for the seven day period. The provider confirmed this programme of events bore no relation to the activities that were provided and was well out of date. Care staff arranged activities during the afternoons in addition to their care duties. We saw a small group of people enjoyed and engaged in a game of bingo during the afternoon. The manager told us that the provider had agreed to recruit a person to arrange and facilitate recreational activities.
Two people who were living with dementia were particularly at ease cuddling baby dolls. They were both fully engaged in looking after and nurturing the dolls. Recent evidence suggests the use of dolls can have a positive impact on people with dementia in residential care.

Staff told us that a person was at times resistive when they required help with their personal hygiene. This person was unable to fully recount their experiences with us but said they were 'fine' when we asked after their welfare. Staff explained the action they took to support the person when support was needed. They told us how they would leave the person for a short while and return to offer support. We saw the behavioural management plan for this person accurately corresponded with the explanations offered by the staff.

People who used the service were unsure of the action they could take if they had any concerns with the service. One person said: "Well I suppose I would speak with the manager or my family when they visited. I am fine though at the moment and have nothing to complain about". The provider had a complaints procedure and this was displayed on the notice boards in various areas around the service. The manager told us they had not received any complaints since they had been at the service but explained the procedure and the action they would take.

Requires Improvement

Is the service well-led?

Our findings

There was a new manager in post; they had been at the service for three months. They had not yet registered with us. Although some improvements had been made in relation to some aspects of medicine management since our last inspection, the provider continued to be in breach of a number of Regulations of The Health and Social Care Act.

The manager had identified some gaps in the monthly audits and had started to implement a regular system for auditing the service. They had completed a catering audit which identified some concerns with cleaning schedules. We saw action had been taken to ensure the cleaning was completed and a record kept. An analysis of accidents including falls had been completed. The manager told us this monthly analysis would swiftly identify any themes or trends emerging from the accidents.

However, we saw some areas of concerns in regard to infection control that had not been identified by the provider through previous audits. These included the lack of sluice facilities for the safe disposal of bodily waste and the effective cleaning of commodes. Staff told us the shower and bathrooms were used for disposal and cleaning of commodes. Staff told us people were not provided with their own individual sling when the use of the hoist and standaid was required. We saw the same sling being used on different people when support with moving was needed. Some soap dispensers were empty so people were unable to wash their hands following use of the toilet. No waste bins for the disposal of paper towels and incontinent pads were on top of the toilet cisterns. These issues constituted an infection control risk. We spoke with the manager about our findings; they said they would take the necessary action to reduce the risk of the spread of infection.

We became aware of an intermittent malodour in the dining room and ground floor corridor. The provider and maintenance person told us this was caused by the drains and sewers. This meant this was not a pleasant environment in which people lived, worked and visited. The maintenance person was unsure what action could be taken to remedy the situation.

The manager had arranged for resident and staff meetings to be held at regular intervals. Following a recent resident meeting a person had stated that a shower was not working. The manager arranged for the shower to be mended and it was now in working order.

We saw the provider had displayed our rating and the latest inspection report of the service on the notice board at the entrance to the service. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided.

People told us they liked the new manager and felt well supported by them. As with previous managers, staff hoped that the new manager would stay and provide some stability and consistency to the service. Staff we spoke with said that Butterhill House was a good place to work but needed some stability in the management and leadership structure of the service.