Care Quality Commission

First For Care Limited

Butterley House

Inspection report

Coach Road
Butterley
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Ratings

Overall rating for this service	Inadequate ●

Is the service safe?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

About the service
Butterley House is a residential care home providing personal care to 23 people aged 65 and over at the time of the inspection. The service can support up to 37 people.

The accommodation is provided over two floors. The upper floor has bedrooms, toileting and bathing facilities. The downstairs also has bedrooms and toilet and bathing facilities with the addition of communal spaces, a conservatory and a dining space.

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

The provider had not always provided us with assurances in relation to the governance of the home. There were insufficient systems in place to monitor the care and ensure people were safe from harm or risks mitigated.

Audits had not always been completed or used to develop improvements. Staff did not feel there was an open culture in the day to day running of the home or their concerns were addressed.
The systems in place to have oversight of staff training, medicines management and risk to people were not thorough enough to manage and improve the service. We found risk to people in relation to pressure care and falls management. We also found staff lacked the training and skills to support people in these and other areas of care.

Information about people's dietary needs had not been shared and this placed people at risk of receiving a meal unsuitable for their needs. Care plans and risk assessments associated with dietary needs had not been completed

Opportunities to learn from incidents had not been followed and we saw this had impacted on the risk in relation to safeguarding and keeping people safe from harm.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Relatives felt they had been provided with information about the pandemic, however they were not always kept informed of day to day events about their relative.

Partnerships which had been established were now being used to affect environmental changes. Infection control was managed well, and the staff were following recent guidance.

Staff recruited to work in the home had received the required checks in relation to references and a police

check. There was enough staff to meet the current occupancy of the home.

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

Rating at last inspection
The rating at the last inspection was inadequate (published 14 February 2020)
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was still in breach of regulations. The service remains in special measures.

Why we inspected

We received concerns in relation to the management of medicines, infection control and governance in the home. We reviewed the information we held about the service. We completed a risk assessment relating to the COVID-19 pandemic that was ongoing at the time this inspection was completed. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Ratings from previous comprehensive inspections for the other key questions were used in calculating the overall rating at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to risk management, safeguarding people from harm, and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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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.

Inspection team
The inspection visit was completed by two inspectors and was supported by two assistant inspectors who made telephone calls.

Service and service type
Butterley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 should have a manager registered with the Care Quality Commission, there was a new manager in post who intended to register with us. They had been brought in by the providers to support the home, following identified concerns. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We contacted the provider by email on arrival at the home and provided details of our inspection process.

What we did before the inspection
We used information we held about the service which included notifications that they sent us to plan this inspection. We spoke with commissioners of the service and some professionals who support people living in the home.

During the inspection-

We informed the provider on the morning of the inspection of the structure of the inspection; we planned to limit time in the home to reduce the risk of infection transmission under current Covid 19 restrictions.

We observed some staff support and interact with people during the inspection visit. We spoke with six people's relatives by telephone about their experience of the care provided. We also spoke with nine members of staff some on site and others by telephone.

We reviewed a range of records. These included care records and incident forms for six people and several medication records. We looked at two staff records in relation to recruitment and supervision. A variety of records relating to the management of the service, including audits, were reviewed.

After the inspection
We asked the provider to complete an action plan to reflect on how they would address the concerns we identified. We completed a feedback meeting after the inspection off site by telephone conferencing.

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management, Using medicines safely
- People were placed at risk of skin damage. We found three people required regular repositioning, the records showed these people had not been moved in accordance with their care plans.
- Dietary requirements had not been assessed and information shared with staff to ensure they would receive the required nutrition to support their diabetes. We found two people had not been placed on the list for a diabetic meal and staff were unaware of these needs.
- There was no specific care plan to address any risk to the people's diabetes should they have a reaction to high or low blood sugar changes. Only three out of fourteen staff had received diabetes training. This lack of training and guidance for staff, put people at risk of diabetic needs being responded to unsafely.
- One person was identified as requiring monitoring for their hydration needs, these had been recorded, however the records showed the person had not received the required amount to reduce the risks associated with their long-term health condition. no action had been taken to address these concerns.
- Other people were not offered a choice of meal and received the same meal daily, this meant they were at risk of not receiving a balanced diet.
- Peoples behaviours had not been monitored. We found information relating to managing behaviours had not been shared with all the staff. Not all incidents were recorded consistently, this meant mental health professionals supporting this person would not have a clear picture of the behaviours and therefore provide the correct ongoing support.
- Some people's prescribed medicine records were handwritten. There was no process for checking that handwritten records were accurately recorded. This meant that writing errors could occur and would not be recognised quickly. Staff did not have clear guidance on when to give people medicines that were prescribed on 'As needed' basis. This meant we could not be assured about the safety procedures in place when managing people's medicines.
- Many of these concerns had been identified in our last inspection. The provider told us in their action plan these areas of concern had been addressed, however we found people continued to be placed at risk and system were not monitored consistently.

The systems in place were not robust enough to demonstrate safety was effectively managed. This placed

people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had not ensured that systems were safeguarding people and reducing the risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

Systems and processes to safeguard people from the risk of abuse, learning lessons when things go wrong
- People were not always protected from the risk of harm. We found two incidents which had occurred had not been reported to us or the local authority. These related to a head injury and a choking incident. This meant we could not be assured all concerns had been considered to reduce the risk of harm.
- Lessons had not been learnt from safeguarding investigations. The provider had not considered what measures should have been in place and how to reduce the risks to other people. After we raised concerns the provider implemented a new falls flowchart, however we found this had not been used effectively in reducing the risks and one person received further harm.
- This shows that although the provider had taken steps to put in place safety measures, they had not ensured measures were used to avoid a repeat of the same concerns reoccurring.

The systems in place to fully investigate any potential risk of harm were not enough to protect people. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
- There was enough staff to support the number of people currently using the service, however we found the staff did not always have the required qualification, competencies, skills and experience to provide care safely.
- Not all staff had received training in pressure care and falls. This was reflected in the lack of importance placed on repositioning being completed in a timely manner. Assessments or measures were not put in place to reduce people's risks.
- Staff had received mental capacity training. However staff did not have good knowledge in this area. Showing that the training had not been effective.
- Staff competencies had not been checked to ensure understanding of the training they had received or to consider if they required further training
- We reviewed the recruitment records for the service. The required checks had been completed which included references and a police check before commencing their role.

Preventing and controlling infection
- Infection control practices were in place, which included known risks associated with the current Covid-19 pandemic.
- Staff had the required personal protective equipment (PPE) in line with national government guidance to protect themselves and people living in the home.
- Improvements had been made in the prevention of the risk to infection. The home was clean, and measures were in place to ensure continued daily cleaning to reduce the risks.

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to effectively implement systems and processes to manage risks to people living at the home. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care
● The provider or nominated individual had not established clear supervision or management of the home, ensuring oversight during the pandemic. The initial action plan the provider completed after this inspection lacked the oversight we had requested and did not provide us with ongoing assurances.
● The audits we reviewed were not consistent and other audits had not been used to drive improvements or changes to reduce risk. At the last inspection we identified poor medicine management. We found similar findings at this inspection. A weekly medicine audit had not occurred for the last three weeks. This poor oversight meant that the provider could not make the required improvements.
● Incidents records had not been used to review repeated events to consider what action could be taken to reduce the risks. We found several incidents in relation to poor management of diabetes; however, no measures or training were identified to reduce these risks.
● Falls had not been monitored consistently and measures implemented after a safeguarding investigation was not followed to reduce the risks to people from harm.
● The delivery of care was not always based upon best practice. We found inappropriate mental capacity assessments had not been completed and DoLS referrals had been made on the back of these without a decision specific assessment or best interest process. We identified this as a concern at the last inspection and had been given assurances that this had been resolved. We found this to be incorrect.
●Policies were ineffective at guiding high quality care. The policies related to paperwork that was not in use, or policies were not always followed when needed.
● Many issues found during this inspection were identical to those found during our last inspection. This meant the required action had not been taken or monitored by the provider or nominated individual to provide the assurances we need to reflect the home has good governance arrangements in place.

Systems in place to monitor the service provided and ensure good outcomes for people were not always effective. This was an ongoing breach of regulation 17 (Good Governance) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

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

● Some staff were confident to raise concerns, however other staff felt they were not listened to or involved in the development of the home.
● Staff we spoke with felt there was not an open culture, they told us at a recent meeting they were deterred from whistle blowing. We asked the provider to acknowledge staff issues and respond to them as a complaint so that they showed a commitment to recognising their contribution.
● Relatives we spoke with felt they had received information about the pandemic, however did not always receive regular updates about the care for their relative. One relative said, "You only get to hear when things have gone wrong, not the good stuff."
● This meant we could not be assured that the communication methods in place promoted an inclusive and open culture.

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 submitted statutory notifications, however we found two events had not been reported to us.
● We noted the codes used to represent the person were not individual or consistent. This meant when we reviewed the information, we could not always be sure who it related to.

Working in partnership with others

● The provider worked with health and social care professionals. We spoke to a health care professional, who reflected that some improvements had been made, however felt communication could be improved.
● The provider had also worked with the local infection control lead to consider measures to improve the daily environment in reducing the risk of infection.

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

● People had been engaged in meetings and we saw actions had been reflected in a 'You said, we did' board displayed in the reception.
● Information had been shared with relatives in relation to the pandemic and any visiting or contact arrangements.