The Elms Residential Homes Limited

Butterhill House

Inspection report

Coppenhall
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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

Overall summary

This inspection took place on the 4 March 2015 and was unannounced. At our previous inspection in June 2014 we found that the provider placed people at risk because of the unsafe storage and administration of medication. The provider did not offer enough stimulating and interesting things for people to do and people were not always involved in their own care planning.

At this inspection some improvements were noted in the environment, however further improvements were required. You can see what action we told the provider to take at the back of the full version of the report.

Butterhill House provides accommodation and care for 28 people. At the time of the inspection there were 24 people using the service.

There was a new manager in post. They had been in post for seven weeks and they were yet to register with us. 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.

Summary of findings

People were not always able to have their prescribed medicines because there were insufficient numbers of trained staff. People had not had their medication needs reviewed.

Systems to keep the home clean were not adequate. The communal areas required thorough cleaning and the facilities to handle waste need reviewing.

People were at risk of having their liberty restricted. The provider did not consistently recognise the requirement to work within the guidelines of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty safeguards (DoLS). The Mental Capacity Act (MCA) is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so.

People were not always treated with dignity and respect. Some observations had shown some staff to be disengaged and disrespectful. Care plans were not always followed to ensure that people remained independent and had the support they required. Consideration to people's privacy had not been made in relation to the environment.

Some limited hobbies and interests were available within the home, however people were not being supported to access the community and they wished to.

People had their health and nutritional needs met. People were supported to attend health appointments and referrals to health professionals were made in a timely manner.

The new manager had begun to implement new quality monitoring systems to improve the service. People and their representatives felt that positive changes had been made.

Summary of findings

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. Staff did not have enough information to be able to care for people safely. People were not always able to have their prescribed medication due to a lack of suitably trained staff. The manager and staff knew what to do if they suspected abuse.

Requires Improvement

Is the service effective?
The service was not effective. People were at risk of having their liberty deprived as the provider did not follow the principles of the MCA and ensure decisions were made in people's best interests. People's nutritional needs were met and they were supported to have their health needs met.

Requires Improvement

Is the service caring?
The service was not consistently caring. People were not always treated with dignity and respect. People's personal items were not treated with respect and the environment meant that some people's privacy could be compromised.

Requires Improvement

Is the service responsive?
The service was not always responsive. People did not always have their individual needs met. People were not supported to access the community and they had requested to. People knew how and who to complain to if they had any concerns.

Requires Improvement

Is the service well-led?
The service was not well led. Further improvements were required to ensure that all of people's needs were met. The new manager had begun to implement quality monitoring systems. Staff told us they liked and felt supported by the new manager.

Requires Improvement

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 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.

This inspection took place on the 4 March 2015 and was unannounced.

The inspection team consisted of two inspectors.

We looked at the information we hold about the service. This includes notifications of significant events that the manager had sent us, safeguarding concerns and previous inspection reports.

We spoke with eight people who used the service and observed their care. We spoke with the manager, and seven members of staff. We looked at six people's care records, staff rosters, the staff training records, three staff recruitment files and the manager's quality monitoring audits.

We spoke with two relatives of people who used the service and a commissioner of services to gain their views.

Requires Improvement

Is the service safe?

Our findings

Previously the provider did not have safe systems in place to store and administer people's medicines, the provider was in breach of Regulation 13 of The Health and Social Care Act 2008. At this inspection we found that some improvements had been made. The medicines were now stored in a locked room and staff dated creams and ointments when they opened them to ensure that they were safe for use. However, we found that people still did not have protocols in place for the use of PRN (as and when) medication, such as pain relief and inhalers. We asked a senior care staff how they knew when people required their PRN medication and they told us they would ask them. Some people would not be able to tell them due to their dementia. We looked at people's medication administration records (MAR) and saw that people who were prescribed pain relief on a PRN basis were being given the maximum dose every day. It was not recorded that the person had been asked but there had been no review with the person's GP to discuss the amount of PRN medication being used.

Senior staff were trained to administer medication. However there were at least three nights a week when there were no trained staff to administer people's PRN medicine in the night if they needed them. Two people were prescribed emergency medication for symptoms of angina, several people were prescribed inhalers for asthma and other breathing disorders. These people would be unable to have these medicines during the night when there were no medication trained staff on duty. The manager was unable to tell us how these people would be able to have their medicines if they required them.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

One person who was living with dementia had risk assessments to be able to support them to remain independent by using the kitchen and by being able to keep their own items that may have presented a risk. This person told us: "I like to keep busy and help out". This person accessed the community alone and they were at risk due to their dementia. Staff were not able to tell us how they planned to minimise the risks for this person. The person had mental health care needs which meant they would be vulnerable within the community. We discussed this with the manager who acknowledged that this person was at risk when out alone and informed us that a risk assessment would be implemented.

Several staff told us that they felt there were insufficient staff on duty and they wished they had more time to spend with people. Day staff told us that night staff were concerned about the staffing levels at night as there were only two carers and when they were supporting a person who requires two staff for support in one area of the home there were no staff available in the other areas of the home. A member of staff said: "Night staff do the cleaning in communal areas, bathrooms and toilets, peel the potatoes, finish laundry all in addition to providing support". We looked throughout the home and saw that most people had sensor mats on the floor by their beds. These mats alerted staff to the fact that the person was getting up. We were told that these mats had been put in place to alert the night staff that the person was moving about rather than being an assessed need.

The manager and staff told us that the night staff were also responsible for the cleaning of the main downstairs communal areas. We saw that the dining area was dirty, with food on the floor prior to breakfast and dining room chairs that had food and stains in the joining areas. The bin was dirty as was the food trolley. The dining area had not been cleaned. We discussed this with staff and they told us that it was because they didn't have enough staff and time to complete all their given tasks.

When we arrived we saw that the bins outside were overflowing with rubbish. There were bags of open rubbish on the floor, with food and other items left out in the open. We saw that some staff were wearing uniforms and some were not. We asked staff why this was. One staff said: "I had to buy my own", another member of staff told us: "The provider doesn't want us to wear uniforms". The home had no sluice facility and we were told that commode pots were washed out in the baths, which were then used for people to bathe in. Staff were having to do this task without any uniforms which meant there was a risk that they would be splashed with bodily fluid on their own clothes.

People who used the service told us they felt safe. Staff we spoke to all told us they would report any signs that

Requires Improvement

Is the service safe?

someone had been abused to a senior or the manager. The manager had raised a safeguarding referral with the local authority for investigation. This showed that the provider responded when they suspected abuse.

The provider followed safe recruitment procedures when employing new staff. We saw that staff had been checked for their suitability to work prior to being offered the job. On one staff file we saw that the provider had been unable to gain a reference for one person and they had implemented a risk assessment to demonstrate how they had ensured they were suitable to work with people.

Requires Improvement

Is the service effective?

Our findings

We saw some people who used the service may not have capacity to make certain decisions. The Mental Capacity Act (MCA) is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. Staff we spoke with had limited understanding of the MCA and DoLS procedures. We saw one person who used the service was seen to be sitting in a recliner chair whilst being supported to eat and staff told us the person lacked the capacity to agreed to this. We looked at this person's care records and saw that they were living with dementia. The physiotherapist had recommended the use of the chair to 'stop the person from wriggling out of it'. There had been no best interest meeting to discuss the use of the chair which was restricting the person of their liberty to move and there was no risk assessment for the use of the chair. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We saw another person had a DoLS authorisation referral on their care record. The new manager was unable tell us if any DoLS referrals had been made or authorised by the local authority to ensure any restriction was lawful.

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

We saw two people had a DNACPR order. This is a legal order which tells a medical team not to perform CPR on a person. CPR is a first aid technique that can be used if someone is not breathing properly or their heart has stopped. We saw that the orders had been completed with the GP and the person's representative as the people lacked capacity to be involved in the decision making process.

People had a choice of foods. One person was on a gluten free diet and they told us the provider brought their bread and they chose the gluten free option of meals. We saw that at the chef brought the main meal and put it into the hot trolley in the dining room an hour and a half before the meal was to be served. The food had sat in the hot trolley for over an hour. We observed that the chef did not probe the food to ensure that it was the correct temperature before serving it to people. There was a homemade chicken pie or gammon. There were three choices of shop brought desserts for a sweet. People told us the food was fine. One person told us: "It's ok, you get a choice". Another said: "It's gammon today my favourite". Some people were prescribed food supplements and saw that the ones being stored were out of date.

People had their health needs met. One person told us: "I only bumped my arm the other day and the staff took me to A&E for a check-up, they are very good like that". We saw a visiting GP, physiotherapist and one person was escorted by a member of staff to a hospital appointment. We saw in people's records when people had a change in health identified the staff responded quickly. Referrals were made to community psychiatric nurses, dieticians and other external health professionals when necessary.

We spoke to a new member of staff who confirmed that they had a period of induction prior to being able to work unsupervised. They told us: "I worked alongside other staff for eight shifts before working alone. It was good. I felt very comfortable with this and it gave me a good understanding of the needs of people".

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were caring, one person said: "The staff are brilliant, they do care". Another person said: "They don't make me feel embarrassed when they help me bathe".

However, we observed people living with dementia being supported at breakfast with little or no interaction. One person with a visual impairment was supported by care staff to the dining table and then left alone. They were brought a bowl of porridge and it was put it in front of them. The person proceeded to eat it with their fingers. We asked a senior member of staff if this was how the person chose to eat their food and they informed us it was not but they did like to be independent . A care staff member gave the person a spoon and they proceeded to eat with it. The care staff then left the person to do something else, and the person began to overfill the spoon and drop food down them self. Another member of staff then came over to the person and took the spoon off the person and began to feed them with the spoon whilst standing over them. Although the care staff interacted with them they had taken away their independence and the person had not been treated with dignity and respect.

We looked at this person's care record. It was recorded that they should be communicated with at all times throughout any interaction due to their sight impairment and that staff should sit with the person at mealtimes and encourage them to be independent. Later at lunchtime we saw that this person was again being fed with a spoon in the lounge by another member of staff.

Another person living with dementia sat at the breakfast table with their breakfast in front of them for approximately 45 minutes without any attempt to eat it. A member of care staff went over to the person to encourage them to eat. There was no interaction with the person and the staff member was disengaged, staring out of the window while holding the spoon up towards the person's mouth. Eventually the person was given some toast. They were then left to eat the toast alone. At one point the person started to cough until tears were visible, they did manage to clear their throat but staff had made no attempt to support the person.

We looked at this person's care records. It was also recorded that they should be communicated with and encouraged to eat as they were at risk of malnutrition. Staff had not interacted with this person in a way in which showed the person respect and they had not followed the person's plan of care.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008(Regulated Activities) 2014.

We saw that people's individual items were not always respected. People's toiletries were left in the communal bathing areas rather than being returned to their own rooms. In the laundry room we were shown a large pile of clothes which were unidentifiable. These clothes belonged to people who used the service. The provider was not ensuring that people's personal belongings were respected.

We heard a discussion take place about daily activities and the plans for the rest of the day. The senior staff member said: "We can do some baking this afternoon with people". A member of the staff said: "We're baking nothing" in a disrespectful tone of voice. This demonstrated an uncaring attitude towards people who used the service. We passed this information on to the manager.

Five bedrooms were adjoining through doors. People were able to walk into someone else's room directly from their own room. Some people in these rooms were living with dementia. There were no risk assessments in place to ensure that people's privacy was maintained when people were in their rooms.

We observed other interactions which were positive. One person was supported on a hospital appointment and we saw that they were encouraged to dress for the weather and was given reassurance. On their return the staff member made sure the person was comfortable in the lounge area and then brought them a hot drink. This person was treated with kindness and compassion throughout the interaction.

Relatives and friends were free to visit any time they wished. One relative told us: "I can come and visit anytime I want".

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that people were not actively engaged in activities, hobbies or interests of their choice, this was a breach of Regulation 9 of The Health and Social Care Act 2008. We saw there was now a plan of activities scheduled on the dining room wall. Some people in the lounge area were completing a gentle exercise session and later in the afternoon there were some puzzles available. People told us they only went out when they went with relatives, to hospital appointments or were able to go out alone. A member of staff told us: "We don't get to take people out, we haven't done trips for about six years". We saw that at the last residents' meeting, people had requested to go out on community trips.

At our previous inspection we had found that people who used the service or their representative were not always involved in the planning of their care, treatment and support. We saw that the new manager had invited all relatives to attend people's care reviews and was working on updating all the care plans with people. A relative told us: "They [staff] keep me fully informed in what's going on".

We sat with people at lunchtime. One person was having difficulty cutting the meat served for lunch. Staff did not offer to support them. They told us: "I have arthritis in my hands and find it difficult to cut food but I like to keep trying. When I go out with my daughter for a meal I have a steak knife with a bigger handle which is much better". This person's individual needs had not been assessed and responded to in aid to support their independence in eating.

There were condiments on the table, salt, pepper and tomato sauce for people to use. However they were dirty. The sauce bottle had dried sauce around the top and was clogged and the plastic pepper pots needed washing. We saw that everyone was provided with a plastic beaker at lunchtime. They were of poor quality, some were scratched and stained. People were not offered individual utensils that met their needs and what was provided was not of a good standard.

People told us they were free to do what they liked within their home. One person said: "I help out in the kitchen", another person said: "I get up and go to bed when I like, If I call the call bell they come and help me".

People told us that if they had any concerns they would speak to staff or the manager. One person said: "I have no complaints but would see go to the boss lady who would sort it". Another person said "I have nothing to complain about". A relative told us: "All the staff are very approachable if I have any problems".

Requires Improvement

Is the service well-led?

Our findings

There was a new manager in post, they had been in post for seven weeks. They had not yet registered with us.

Although some improvements had been made in the environment since our last inspection, the provider continued to be in breach of a number of Regulations of The Health and Social Care Act. Care was not being delivered as required in people's care plans; people were unable to have their prescribed medication at night. Some observations had shown that people were not always treated with dignity and respect and the provider was not always responsive to people's individual needs.

Staff told us they liked the new manager and hoped that they stayed. We were told that the manager was approachable and supportive. All the staff we spoke with told us that if they suspected someone had been abused they would know how to whistle blow. Senior staff meetings had recently taken place and staff support and supervisions had begun with individual staff. Prior to the new manager staff had not received individual support and supervision.

The manager had implemented a business continuity plan. The plan informed people what to do in the event of an unplanned emergency. Quality monitoring audits which included medication, complaints, infection control and the analysis of incidents and accidents had also been implemented, although had not identified the concerns we saw.

Plans to meet with residents and relatives were in place. A relative told us: "There have been a few changes since the new manager is in, but for the better". The manager planned to formally review everyone's care twice a year. These reviews would involve all the key people involved in the person's life and care. This would mean that people would be involved in their own care planning.

We observed that the manager was open and friendly with people who used the service, visitors and staff. People told us that they found them approachable.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment of service users must be provided in a safe way by the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users must be treated with dignity and respect.**