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	Inadequate

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

Summary of findings

Overall summary

We inspected Butterhill house in response to information of concern that people were continuing to receive care that was not safe. We previously inspected on 15 and 16 August 2016 where the service was rated as inadequate and placed into special measures. We had begun enforcement action against the provider and asked them to improve. We focused our inspection on the three areas of concern which were people's safety, the effectiveness and overall management of the service. We found that no improvements had been made since our last inspection and people were still receiving care that was not safe, effective or well led. We undertook this focused inspection on the 5 September 2016. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Butterhill House on our website at www.cqc.org.uk.

We found that the service remains Inadequate and it will remain in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Butterhill House provides accommodation and personal care to up to 28 people. At the time of this inspection 17 people were using the service.

There was no registered manager in post and the service was being managed by the provider and consultants who were in the process of registering as the new providers of the service. The new potential providers told us they had recruited a new manager who was due to start in October 2016. 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.

People were not being safeguarded from abuse as incidents of potential abuse had not been reported or investigated to prevent the incident occurring again.

There were still insufficient staff to meet people's needs safely. People were at risk of malnutrion and infection due to a lack of care staff and domestic staff. The provider could not be sure that staff employed were of good character and fit to work with people.

People's medicines were still not managed safely. People did not always get their medicines at the prescribed times and were at risk of not having their medicines due to poor staff practise.

People's individual risk assessments were not followed by staff to ensure that the care they received was safe and minimised the risk of harm. People did not always have the equipment they needed to keep them safe from harm.

The principles of the Mental Capacity Act 2005 (MCA) were not followed to ensure that people were consenting or being supported to consent to their care and support.

People's nutritional needs were not being met and people had lost weight and were at risk of malnutrition.

Health professional advice was not followed and people's health care needs were not always met.

Staff did not receive effective support and supervision to ensure they were competent in their role and this put people at risk of harm due to poor practice.

Systems in place to monitor the quality of the service continued to be ineffective. The management systems were insufficient to provide leadership and guidance to the care staff. People were at continued risk of receiving poor, inconsistent and unsafe care.

No improvements had been made since the last inspection and the provider continued to be in breach of several Regulations of The Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from abuse or the risk of abuse as the provider did not report incidents of potential abuse.

People were at risk as staff did not follow people's risk assessments to ensure that any risk of harm was minimised.

People did not always receive their medicine at the times they needed it and in safe way.

There were insufficient staff to keep people safe and meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

The provider was not following the principles of the MCA by ensuring that people were not being unlawfully restricted of their liberty.

People's nutritional needs and preferences were not always met.

People did not always receive the health care support they needed as health care advice was not always followed.

Staff did not always receive support and supervision to ensure they provided support in a safe effective way.

Is the service well-led?

Inadequate

The service was not well led.

No improvements had been made since our last inspection and there were continued risks to people's health and safety.

There was no registered manager in post and the service lacked clear leadership and management.

There were no systems in place to monitor and improve the

service and professional guidance was not being followed.

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 due to concerns we had received from social care and health professionals who had visited the service following our previous inspection. We inspected 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 5 September 2016 and was unannounced. This inspection was undertaken by two inspectors.

We received information about the service from three social care and health professionals and the local authority.

We spoke with the provider and two consultants who were planning on becoming the new providers of the service. We spoke with four people who used the service and a visiting relative. Some people were unable to speak to us due to their health care needs so we observed people's care in the communal areas and looked throughout the service.

We spoke with four members of staff and looked at care records for all the people who used the service. We looked at the way people's medicines were managed and records relating to the administration of medicines. We looked at staff recruitment and any systems the provider had in place to monitor the quality of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection in August 2016 we had concerns that people were receiving care that was not safe and people were at risk of harm. We found the provider was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We looked to see if improvements had been made and found that not all unexplained injuries to people were investigated to ensure people had not suffered from abuse. Two people had been found to have bruising which could not be explained. We saw that the staff had telephoned people's GP and explained the bruising over the phone. The GP had noted it on their records however no further investigation was conducted to try and ascertain how the bruising had occurred. The provider and staff had not contacted the local safeguarding team to discuss and refer the bruising as a possible incident of abuse. This meant that people continued to be at risk of harm and abuse as the provider was not following the local safeguarding procedures in relation to reporting incidents of possible abuse.

This was a continued breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving care that was safe. At this inspection we found that people continued to be at risk of harm as staff were not following people's risk assessments. We saw one person had been assessed as being at high risk of pressure sores as they were immobile. The person's risk assessment stated they should sit on a pressure cushion at all times to help manage this risk. We observed that this person sat in wheelchair for two and a half hours over breakfast without a pressure cushion. We saw they looked visibly uncomfortable, moving around in their wheelchair. This person also required their continence needs met every two hours. We observed that this person did not have their continence needs met from when they got up in the morning until late afternoon. This meant that this person was at risk of gaining pressure areas due to not having the equipment assessed for them to use and being supported with their personal care regularly.

Several people had been assessed by a speech and language therapist (SALT) as requiring a soft or pureed diet as they were at high risk of choking due to swallowing difficulties. We observed two people being given food which put them at risk of choking and was contrary to the guidance recorded by the SALT. We saw records that confirmed that this happened on a regular basis and people who were at high risk were often being given food such a crisps, sandwiches and cake. The provider was unable to offer an explanation as to why people were being given food that was unsafe. This meant that people were at risk of harm from choking.

Previously people medicines had not always been managed safely and they did not always receive their medicines at the prescribed times. At this inspection we found no improvements had been made and people were still not always receiving their medicines when they needed them. We saw one person was prescribed a weekly pain relief patch which was a classified controlled drug. Some prescription medicines are controlled under the 'Misuse of Drugs' legislation and have stricter legal controls apply to controlled

medicines to prevent them from being misused. We found that there were too many patches available in relation to the amount that had been signed to say they had been administered. This meant that this person had not received their pain relief when it was prescribed. Controlled drugs should be administered and signed for by two members of staff. We saw on some occasions only one member of staff was signing to say that the medicine had been administered. This is contrary to the controlled drugs guidelines and put people at risk of not receiving their medicines in a safe way.

We observed that people's medicines were often left with the person and then signed by the senior staff member to say the person had taken them. The senior staff could not be sure that the person had actually taken the medicine as they had moved away to another area and did not return to check and confirm with the person that they had taken their medicines. We found there were still topical creams in people's room with no prescribing labels on. This meant that the staff could not be sure that the cream belonged and was prescribed to the person and there were no instructions as to when and where the cream should be applied. Stocks of medicines did not balance with the records that were kept. Several people's medicines were unaccounted for with no clear audit trail as to where they were. A staff member told us: "I don't know what has happened since the previous manager has left, nobody is checking now". This meant the provider could not be sure that people were having their medicines safely and at the prescribed times.

People were at risk due to the poor maintenance and poor cleanliness of the environment. We saw the belt on the chair lift was broken and would not have safely secured people when using the chair. We found the laundry door was propped open with dirty clothes and machinery easily accessible to people. The fire alarm sounded during the inspection and we saw that several internal doors were propped open and did not automatically close when the alarm sounded. This included several people's bedroom doors. This put people at risk in the event of a fire as they would not be protected behind a fire door. The provider had arranged for an agency domestic staff to clean the main areas of the service; however we found that people's bedrooms, bathrooms and private areas were still unclean and unhygienic. For example we found people's beds were made with sheets which were soiled. Commodes that had been used in the morning had not been emptied by the late afternoon and rooms were left in unclean and untidy state. People continued to be at risk of infection due to poor cleaning and hygiene standards.

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

We had previously found that the provider was in breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as they had insufficient staff to keep people safe and meet their needs. Staff numbers had not been increased following our previous inspection and we found that there was still insufficient staff to safely meet the needs of people who used the service. The domestic staff member still only worked three mornings a week and the service remained unclean and unhygienic. There were not enough domestic staff employed to maintain the cleanliness of the service on a daily basis. People who required support to eat and drink did not receive it as there were insufficient care staff to be able to support people at meal times and people had lost weight. People who were frail and at risk of falling were left unsupervised in the lounge areas for periods of time throughout the day. The lack of sufficient staff put people at risk of harm to their health and wellbeing.

This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had previously looked at the way in which staff had been recruited to check that robust systems were in place for the recruitment of staff. We had found that the provider was in breach of Regulation 19 of The

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as checks of people's suitability of work had not been undertaken. We found that in one personnel file we inspected we had found that references had been gained but these had not been translated in English. We were unable to ascertain the suitability of the references. The provider was sure the references had been translated but was unable, at the time of the inspection, to show us the translated copies. At this inspection the provider had still not been able to show us translated copies of the references. This meant that people were at continued risk of receiving care and support from people who may be unsuitable.

This was a continued breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations2014.

Inadequate

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The Deprivation of Liberty Safeguards (DoLS) is part of the MCA. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

At our previous inspections we found that the provider was not following the principles of the MCA people were being restricted of their liberty through the use of bed rails, sensor mats and from being under constant supervision. We found the provider was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that although some DoLS referrals had been made not all restrictions in place had been considered and referred to the local authority for authorisation. The provider was still unable to tell us who had been referred to the local authority and who had not. This meant that people continued to be at risk of being unlawfully restricted of their liberty.

People were still not always consenting or being supported to consent to their care and support. One person had previously been requesting to stay in bed for long periods of the day and this was putting them at risk of malnutrition and skin breakdown. The person lacked mental capacity to make an informed decision and would be unaware of the risks. A best interest meeting involving the person's representatives had not been held to ensure that this decision was in their best interest. At this inspection we found that a best interest decision had still not been made and although the person was up on the day of this inspection they still chose to spend long periods of time in bed.

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

Previously some people had complained about the quality of the food and the choices available to them. At this inspection we saw that people's nutritional needs were not being met and they were at risk of malnutrition. Health professionals had identified at a recent check of the service that several people had lost weight. We saw that at least four people had lost a substantial amount of weight and advice had been sought from health professionals but this was not then followed. For example one person's GP had informed staff at the service that they would not prescribe food supplements but advised that staff sat with the person and encouraged them to eat instead. We observed this person say they were hungry midmorning, two hours before lunch was served and they we informed by a member of staff "You've just had your breakfast, it will be lunch time soon". The staff member didn't offer or encourage the person to eat anything when they asked. At lunchtime we saw the person was presented with some lunch staff left them alone with it. No staff sat with the person and encouraged them to eat as advised by the GP. The person had a couple of mouthfuls of food and pushed the plate to one side and a member of staff picked it up and put it in the bin with no comment or encouragement to the person to eat more. We saw that several people had been

advised by a dietician to have a fortified diet to help promote weight gain. We asked the staff member who was cooking, how they fortified the meals and they were unable to tell us and we saw there was no ingredients available in the service to fortify the food. We observed several people leave the food that was presented to them and staff members did not make comment or encourage them to eat any more. We saw two people were given food that was unsafe and put them at risk as they had swallowing difficulties. This meant that people's nutritional needs were not being met and people were at risk of malnutrition.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously people s health care needs were not always met and instructions from health professionals were not always followed. There was a failure to observe the express instructions of health professionals. At this inspection there had been no improvement and health professional advice was still not being followed. For example we saw the person whose GP had requested that staff sit with them and encourage them to eat, was not supported as advised. We saw other people who had been assessed by the speech and language therapist as needing a fork mashed or pureed diet because of problems with swallowing were given food that put them at risk. There were other people who required fortified food and this was not available to them. We saw one person who had been advised to use a pressure cushion at all times to prevent pressure areas did not have the cushion available to them. This meant that people's health care needs were not being met as staff were not following the advice of the health care professionals.

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

We previously had concerns about the support and training staff received to ensure they were effective in their role. We found that the provider was in breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider told us that training was on-going however it was not clear from records what training staff had received prior to being employed and during their employment at the service. We saw staff were not always effective in their role and their competency to complete their role was not always monitored. For example we saw a senior member of staff administer people their medicine in a way that was not safe. When we spoke to the staff member about this they recognised they were not following the correct procedure. This had not previously been identified by the provider or previous manager through supervision or competency checks. Staff did not always follow care plans and risk assessments in relation to their pressure care and nutrition and this put people at risk. This had not been identified through support and supervision with the individual staff members. This meant that people were not receiving care that was effective from staff who were supervised and supported to fulfil their role in a way that met people's needs and kept them safe.

This was a continued breach of Regulation 18 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found that the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014 as the systems they had in place to monitor and improve the service were ineffective. Since our previous inspection in August 2016 the manager had left and the service was being managed by the provider supported by the consultants who were in the process of registering to become the new providers. We were informed that a new manager had been appointed and was due to start in October 2016.

We found that although the new consultants had plans in place to improve the service the current provider had not made any improvements since our last inspection and people were still not receiving care that was safe, effective or well led. We found there were continued breaches of Regulations of The Health and Social Care Act 2008 and a new breach in relation to people's nutritional needs not being met.

People's freedom and liberty was still being compromised and care was not being delivered in accordance with consent or the principles of the MCA. The provider was still unable to tell us who was being legally restricted of their liberty and who had been referred to the local authority for authorisation of any restrictions which were in place. There were still no systems in place to ensure that the provider were able to be sure people were not being unlawfully restricted of their liberty.

Systems and processes were still not in place to effectively monitor and improve the quality and safety service or to mitigate any risks relating to the health, welfare and safety of people who used your service. The provider was not following the local safeguarding procedures by ensuring all potential incidents of abuse were reported and investigated to ensure that people were safe and not at risk of harm.

We found continuing issues and concerns with the infection control. Effective systems were still not in place to ensure the equipment in use and the environment was clean and hygienic. The provider had organised for an agency domestic to complete a deep clean of some of the communal areas however people's bedrooms, beds, toilets, bathrooms and commodes were still left unattended and unclean during the day. People were still at risk of cross infection and there was an immediate risk to people's health posed by the extremely unhygienic physical conditions.

There were still insufficient staff to support people with their individual care and support needs in a timely way. Staffing levels had not been increased since the previous inspection. People were at risk of malnutrition and had lost weight as staff did not have the time to sit and encourage people to eat. The environment remained dirty and unhygienic as there were insufficient domestic staff to be able to clean and support care staff with laundry and hygiene tasks.

People's health care needs were still not being consistently met. Guidance from professionals and treatment plans were still not being followed. People were at risk from choking, weight loss and pressure sores due to staff not following people's care plans and health professional advice. People's healthcare needs were not being effectively monitored by the provider and staff's competency and practice was not being effectively

managed. There was a lack of clear leadership and staff were not being supported and managed to ensure that they were competent in their role and accountable for their actions.

People were not always receiving their medication at the times they were prescribed. This had not been identified by the provider as there was no medication audit in place to identify any missed medicines or other errors. We were told that no one had audited the medicines since the previous manager had left.

These issues constituted a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.