# Butterfields Home Services Limited

# Kingdom House

## Inspection report

6 Prowses Meadow
Kingdom Lane, Norton Fitzwarren
Taunton
Somerset
TA2 6QP

Tel: 01823211112

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21 November 2019

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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| 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? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Kingdom House is comprised of two separate services based at the same address. Kingdom House is a residential care home which is registered to provide personal care for up to three people with a learning disability and/or autism. One person lived there when we visited. It is a two-storey domestic home in a residential area.

The second service, Butterfields Home Services is a domiciliary care agency, which is managed from an upstairs office at the home. This service was previously registered at a different address. It moved to Kingdom House and started operating in January 2019, following a period of dormancy. It now specialises in providing end of life homecare services for people in the last weeks of life in the Taunton, Wellington, Minehead, Ilminster, Chard and Yeovil areas. People are referred to Butterfields Home Services by Somerset Continuing Health Care (CHC) team, following an assessment of their end of life care needs. The service includes multiple day time visits and night sitting services, according to people's changing needs.

Since the last inspection the previous registered manager had died. A new registered manager had been appointed but four attempts to recruit and register a second manager to manage the domiciliary care agency were not successful. On the first day of the inspection, a new care manager had been appointed and was undergoing induction.

People's experience of using this service and what we found
A lack of management support and changes to the agency to provide end of life care without the proper support systems in place had destabilised the service and created potential risk to people's quality of care and safety.

People were at increased risk because many of the quality monitoring systems previously in place had lapsed. This meant the provider had not sufficiently mitigated risks relating to the health, welfare and safety of people using the service. During the inspection, we identified seven breaches of regulations in relation to safe care and treatment, good governance, staffing, recruitment and a failure to notify Care Quality Commission in three areas. Further actions were needed to address risks and make required improvements.

People said they felt safe and we found no evidence that people had been harmed. However, systems were either not in place or were not robust enough to demonstrate safety was effectively managed. People's care records and risk assessments lacked detail to instruct staff about their care and treatment needs. For example, about moving and handling, pressure ulcer prevention and equipment risks. Newly recruited staff were not thoroughly checked before they began to work with people, staff performance concerns were not followed up robustly.

People were at increased risk of not receiving effective care. The provider systems did not ensure staff had the qualifications or competencies, to enable them to carry out their role. Staff did not receive all the

appropriate support, training, supervision and appraisals needed for their ongoing development.

Homecare agency records did not provide detailed personalised information about people's current care and treatment needs. For example, re catheter care, moving and handling needs or about how to manage a skin wound. There was also a lack of personalised details about each person, which would make it harder for staff to get to know them.

Kingdom House has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. The outcomes for people using the service reflected the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. People's support focused on them having as many opportunities as possible for them to gain new skills and become more independent.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. Although staff understood principles of best interest decision making, for people who lacked capacity, improvements in documentation were needed to capture best interest decisions.

People and relatives praised the care people received and said staff were caring and compassionate, and treated people with dignity and respect. They said the service was responsive to their needs.

Following the inspection, the provider sent us an action plan of improvements already under way, and outlined the steps they planned to take to make further improvements

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

Rating at last inspection - This is the first inspection of Butterfields Home Care services, since the agency was registered at Kingdom House in October 2018 and started operating in January 2019. Previously, these services were registered at separate addresses when we last inspected them. Kingdom House was rated Good (April 2018). Butterfields Home Care Services was rated Good (report published 2017).

Why we inspected
The inspection was brought forward because of concerns raised with the Care Quality Commission about poor recruitment, leading to potentially unsuitable people working with vulnerable people. Also, a lack of staff training, particularly in relation to medicines management, moving and handling autism and the use of restraint. Concerns were also raised about leadership and quality monitoring at the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Following the inspection, the provider sent us an action plan outlining steps being taken to address these risks.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the

findings at this inspection.

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

Follow up
We will request an updated action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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| **Is the service safe?**<br>The service was not always safe.<br>Details are in our safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was caring.<br>Details are in our caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-Led findings below. | **Inadequate** |

# Kingdom House

**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
One inspector visited the service.

Service and service type
Kingdom House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Butterfields home care agency, a domiciliary care agency is also run from Kingdom House. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was managing Kingdom House and Butterfields home care agency.

Notice of inspection
This inspection was announced. We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. The inspection started on 18 November and ended on 21 November 2019.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
On 18 and 21 of November 2019, we visited the care home and met the person who lived there and visited the agency's office. On 19 November we accompanied a care worker on four home visits, and telephoned others receiving the service. We spoke with two people and four relatives. We looked at seven people's care records and at five medicine records.

We met with the provider, registered manager, deputy manager and a new care manager who started working at the agency on the first day of the inspection. We also spoke with five care staff which included staff who worked in the care home and staff working in the care agency.

We looked at systems for recruitment, supervision and at staff induction and training records. We also looked at quality monitoring systems relating to the management of the service, such as daily checklists, audits, policies and procedures as well as servicing and maintenance records. We sought feedback from commissioners, and health and social care professionals who worked with staff at the home. We received a response from one of them.

Requires Improvement

# 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 Good for both services. At this inspection this key question has now deteriorated to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment; Systems and processes to safeguard people from the risk of abuse

- We followed up concerns raised with the Care Quality Commission about poor recruitment, leading to potentially unsuitable people working with vulnerable people.
- People were not fully protected from harm as the provider did not have robust recruitment checks in place. This meant checks were not robust enough to make sure new staff had the right skills and attitudes to work with vulnerable people. For example, there were no records of interviews or evidence that gaps in employment, reasons for leaving or missing references were followed up. New staff were regularly working with people before their criminal record checks were completed, although the provider assured us they always worked alongside other staff.
- Where staff had disclosed criminal records, risk assessments were not robust enough to protect people from the risk of abuse. For example, additional supervision arrangements planned to make sure those staff were suitable were not completed.

This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider sent us an action plan, which included immediate plans to improve their recruitment processes.
- Staff undertook safeguarding training and were familiar with how to recognise and report signs of abuse. Where concerns about suspected abuse were raised, the provider reported them to the local authority safeguarding team and worked with them to protect people but hadn't notified the Care Quality Commission.
- People felt safe with the staff who supported them. People's comments included; "The service is reliable, staff stay as long as needed," "[Name of person] feels very safe in their hands."
- The service had sufficient staff to meet people's needs. People were supported by a small team of staff they got to know and trusted. Agency staff worked long days to provide people with continuity of care, by minimising the amount of staff visiting people each day. Where people required two members of staff to care for them, these were always provided. Where a person's condition changed or deteriorated, the agency was able to visit for longer or do additional visits.
- The person who lived at Kingdom House also had a small dedicated staff team, who knew the person well, and provided them with continuity and consistency.

Assessing risk, safety monitoring and management

● We followed up anonymous concerns raised with us about safety risks for people related to a lack of staff training, particularly in relation to moving and handling, positive behaviour support and the use of restraint.

● People were at increased risk because the provider had not ensured staff had the qualifications, competence, skills and experience to provide people with safe care and treatment.
● At Kingdom House staff used Managing Actual and Potential Aggression (MAPA) de-escalation techniques to care for a person who experienced behaviours that challenged the service. The person had a detailed risk assessment and behaviour care plan in place, which was well understood by staff. Staff described how sometimes they recognised the person was becoming more anxious or aggressive and knew what steps to take. For example, distracting the person, using various positive behaviour support techniques to help calm the person.
● If necessary, staff also used other techniques, such as wrapping the person in a blanket and a "seated hold" technique to prevent the person or staff being harmed. The techniques used were agreed with their mental health team and outlined in control and restraint procedures. However, the registered manager and the provider were teaching staff to use these specialist techniques. They were not appropriately trained for this role or to assess if staff had the required competencies. This meant we could not be confident staff had the necessary skills or were using safe, up to date techniques.
● At Butterfields Home Services, staff had no detailed instructions about how to minimise risks for people. For example, relating to moving and handling, falls risks, use of bedrails, equipment or about the prevention of pressure ulcers. Although we saw no evidence of harm, staff may not be minimising those risks.
● Staff had not received face to face moving and handling training by an accredited trainer, to teach them how to use approved techniques and equipment to move people safely. Existing staff taught new staff but there were no records of what was taught or of any competency assessments. This meant people could not be confident staff had the necessary skills or were using safe, up to date moving and handling techniques.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On 25 November 2019, the provider sent us an action plan, setting out immediate plans to reduce these risks. The new care manager had devised an individual risk assessment tool for the agency, which included risk assessing the environment of care and assessing people's individual risks and providing staff with detailed information about how to minimise those risks. For example, related to moving and handling, falls and pressure sore risks.

A new care supervisor appointed on the 23 November 2019 was completing an accredited train the trainer courses in moving and handling, so they could train and assess staff practice. The registered manager and the provider had booked to attend a MAPA course for trainers, so they could train and assess staff in use of up to date, safe, positive behaviour support and restraint techniques.

Learning lessons when things go wrong
● Accidents and incidents were recorded at Kingdom House and were discussed with staff to enable them to learn from events and share that learning within the team.
● At Butterfields Home Services, the accident/incident reporting system was very informal via telephone calls. Accidents/Incidents needed to be recorded more clearly, in accordance with the services policy, so any learning or trends could be identified and shared with staff.

Using medicines safely
● People who needed help to take prescribed medicines were supported by competent staff. Staff received

training in the safe administration of medicines and were assessed to check they had the required knowledge and skills to administer medicines safely.

● Staff kept clear records of any medicines administered on Medicine Administration Records. However, where families administered some of the prescribed medicines, they were instructed to write in the MAR charts. This was confusing, because it appeared as if staff had administered those medicines. We discussed this with the provider and registered manager, who said they would look at finding another method for families to communicate this information to care staff.

● Where prescribed creams were being administered by staff, MAR charts lacked details of area of body and how often they needed to be applied. This increased the risk that they might not be used as prescribed.

● At Kingdom House there were clear protocols in place for use of 'as required' medicines, to help a person manage their mood. These medicines were only used after consultation with the registered manager or provider. Records over the past six months showed a significant decrease in their use. Staff explained this was because as they had got to know the person better, they were able to identify subtle changes in their mood and take proactive action. For example, helping them to relax and engaging the person in an activity.

Preventing and controlling infection

● People were protected against the risk of the spread of infection because staff received training in infection control and understood the importance of handwashing to prevent cross infection.

● The provider made sure staff had access to personal protective equipment such as disposable gloves, aprons and handwashing facilities to prevent cross infection.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good in both services. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● We followed up concerns raised with us about staff skills and training. We found people could not be confident they were cared for by staff that had all the required knowledge and skills to meet their needs. This was because of weaknesses in the providers systems for monitoring staff training, supervision and appraisal.

● All new staff completed an induction period where they worked alongside the registered manager and other experienced staff. However, induction records were poorly completed and lacked detail. Where staff were new to care they hadn't completed the Care Certificate in a timely way or at all. This meant there was an increased risk those staff lacked the necessary skills. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected in the health and social care sectors that should be covered by staff new to care.

● Staff had access to a wide range of training through an accredited training provider. For example, health and safety, infection control and safeguarding training. Agency staff had also recently completed End of Life Care training, which was relevant to their work. However, it was unclear which training staff were required to complete, depending on their role. Also, there were no systems to check whether staff have completed necessary training, and no follow up when they failed to do so. This meant several staff were not up to date with vital training such as safeguarding and moving and handling.

● Staff did not receive individual supervision. No 'spot checks' were carried out on staff working for the agency to demonstrate they carried out their duties to the standard required. Appraisal systems had also lapsed which meant staff did not have the opportunity to discuss their professional development needs.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and registered manager explained a lack of office support meant they were fully involved in the day to day running of both services. This meant they relied on informal systems to provide day to day support to staff as they lacked the capacity to monitor staff training or undertake supervision and appraisals.

●Following the inspection, the provider sent us a new training matrix, which showed what training staff needed to complete, which will be monitored by the new care manager. The action plan also included reviewing existing staff training and addressing any gaps. Other improvements showed all new staff will complete a five-day induction training before they start working with people and a newly appointed care supervisor was planning to commence 'spot checks' and check staff competencies.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The local authority undertook an assessment of people's end of life care needs before they were referred to the agency. This information was used to create an initial care plan about each person's needs. After this, the agency relied on visiting care staff to review and update people's care records to reflect their changing care needs.
● Care records we looked at lacked detailed guidance for staff about how to meet each person's care needs. For example, about the care a person with a sore bottom needed or how to assist a person with their urinary catheter. This meant there was an increased risk staff did not have all the information they needed to provide effective care.
● At Kingdom House, staff had detailed guidance about how to meet the person's needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Agency staff worked closely with people's GP's, district nurses and hospice services to meet people's changing end of life needs.
● Staff recognised changes in people's health, sought professional advice appropriately and followed that advice. For example, when a person developed a red area on their bottom, staff followed the advice of the district nurse to manage this.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The person who lived at Kingdom House was subject to restrictions on their liberty for their safety and protection. A recent review of their DoLS by the local authority team praised the efforts of staff in getting the person using their local community more regularly.

● No records of mental capacity assessments and best interest decisions records had not been completed since 2017, although staff said the person had recently had a 'flu' jab and recent dental treatment. We discussed this with the provider who thought staff had recorded these decisions in the person's daily records, rather than using the required documentation. The person's relative confirmed staff involved them in any major decisions and they oversaw their finances.
● People the agency supported confirmed staff sought their consent before providing personal care. Where people lacked capacity, agency documentation did not capture information about consent, or details about legal power of attorney. However, new documentation sent following the inspection incorporated this.

Supporting people to eat and drink enough to maintain a balanced diet
● At Kingdom House, although the person was not able to access the kitchen safely, staff encouraged them with preparing their food. For example, to prepare a packed lunch or jelly.

● People were offered drinks and meal choices and had drinks and snacks within reach before staff left. Staff were aware of people's likes and dislikes and any dietary restrictions.
● Where there were concerns about whether people were eating and drinking enough, staff kept records of food and drink. This prompted staff to offer the person food and drink again at the next visit.

Adapting service, design, decoration to meet people's needs
● At Kingdom House the environment was adapted to provide a low stimulation environment to meet the needs of the person who lived there. This meant there was plenty of storage, so items were put away when not in use.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good for both services. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- A lack of person centred information about people meant staff didn't have details of each person's background, personal history and preferences. This would make it more difficult for staff, to quickly get to know people and establish relationships with them.
- The service did not ensure staff had all the training and support they needed to provide people's care in a compassionate and personal way.
- People and families gave us consistently positive feedback about the caring attitude of the staff. They said staff were compassionate, and treated people with dignity and respect. Comments included; "All the staff are lovely," "I couldn't have asked for better," "You get to know them, and they get to know you" and "We are very pleased with carers, all very good and helpful."
- The provider explained they decided to re-establish Butterfields Home Agency to provide end of life care, following their personal experiences of end of life services for a close family member. This was because they wanted to provide a more flexible, caring and compassionate service, with good continuity of care, which responded rapidly to people's changing needs.
- People confirmed staff protected people's privacy and supported them sensitively with their personal care needs.
- At Kingdom House, staff understood the person's needs well and spoke about them with caring and affection.
- We observed good communication and interactions between staff and people, with staff addressing people by name in a courteous and respectful way.
- Staff knew which aspects of care people could undertake independently, and those they needed care staff support with. For example, that a person could wash their hands and face and clean their teeth but needed help to shave.

Supporting people to express their views and be involved in making decisions about their care

- People and families said staff involved them in making day to day decisions about their care, which we confirmed when we visited with care staff.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good in both services. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences;

- At Butterfields Home Services, people's care records did not provide detailed personalised information about their current care and treatment needs. For example, to instruct staff about how to meet people's individual catheter care, moving and handling needs or about how to manage a skin wound. This increased the risk that care may not meet their needs, was inconsistent and may not reflect professional advice.
- There was a lack of personalised details about each person, their family history, achievements, interests and hobbies. This would make it harder for staff, who didn't know people well to quickly establish relationships with them.
- Record keeping was inconsistent. Staff recorded new information in different places in people's care records. For example, in daily care plans, on a body map or in the important information section.
- Staff communicated people's rapidly changing care and treatment needs verbally between staff, which wasn't always recorded. This meant people's care records could not be relied upon to provide all relevant, up to date information about each person.
- Where people had expressed any advanced decisions about resuscitation, copies of this information were kept. However, there was no end of life care plan to capture people's individual end of life wishes, or what was important to them. For example, regarding presence of family members, any cultural or religious preferences, or preferred funeral arrangements.

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

- We discussed our concerns regarding record keeping for Butterfields Home Services with the registered manager, provider and new care manager. The provider explained they did not have access to the agency's previous paperwork, when the service reopened and hadn't fully appreciated what was needed.
- Following the inspection, the new care manager sent us a new care record format, they planned to introduce, which was much more comprehensive. A newly appointed care supervisor was planning review people's care and update their care records.
- At Kingdom House, the person's care records were detailed, person centred and reviewed. Staff were responsive to their changing needs. When the person expressed a preference to sleep downstairs, staff accommodated this. Staff said the person seemed to gain reassurance from seeing staff nearby whenever they awoke.
- People and relatives praised the care people received. Comments included; "We couldn't have asked for better, the support staff have given [person's name] has been brilliant," "They keep [name of person] cheerful."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● At Kingdom House, there were always two staff working with the person. This meant they were able to ensure the person went out and about in their local community whenever they wished. For example, they enjoyed frequent short walks at local beauty spots, going out in the car and having coffee and cake. Staff said the person also enjoyed helping them with cleaning and housework.

● A relative praised how proactive staff were at encouraging the person to go out and try new things, for example, swimming.

End of life care and support

● People and relatives praised end of life care provided by staff. They appreciated the service was flexible and responsive. For example, staff could extend the length of their visit, if a person needed a longer visit, or if they needed more frequent visits. A relative said they appreciated that the registered manager and provider visited to support them when their relative's condition was problematic.

● Relatives written feedback included; 'Thank you for all your kindness and care of [person] during their last few weeks of life. It was much appreciated,' 'Deepest appreciation of the excellent care and support given. Your team treated [name of person] with such care, sympathy and good humour,' and 'I know you made [persons] last hours really comfortable.'

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were identified and recorded in their care records. For example, whether people needed glasses to read and information about any hearing impairments.

● At Kingdom House, staff communicated effectively with the person by using short simple sentences, along with some simple Makaton sign language. Their care plan included details of words or phrases the person used and what they meant. Also, Makaton signs the person understood, for example, to prompt the person to look and listen.

● Staff were instructed to speak with the person using a 'firm but calm voice' and encouraged them to look and listen using sign language. They described how the person was speaking more and learning new words all the time. For example, learning names of colours and shapes as well as developing their writing skills.

Improving care quality in response to complaints or concerns

● People said if they had any complaints they would be comfortable to raise them with the provider. There was a complaints system in place and people were given written information about how to raise a complaint. This was kept with a care record folder in each person home.

● We followed up a complaint the Care Quality Commission was aware of, which had been investigated and dealt with appropriately.

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 Good in both services. At this inspection this key question has now deteriorated to Inadequate. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 registered manager and provider lacked knowledge of the regulations and how to meet them. Also, about what aspects they were required to notify to the Care Quality Commission (CQC).
- The provider failed to notify CQC about changes to their statement of purpose to reopen Butterfields care agency in January 2019 as an end of life domiciliary care agency. This meant opportunities to identify and seek assurances about these changes were missed.

This is a breach of Regulation 12 (Statement of Purpose) of the of the registration regulations 2009.

- The provider failed to notify CQC about the deaths of people they were providing a service to.

This meant opportunities to identify the service had changed to an end of life care service and seek assurances about circumstances of people's deaths were missed.

This is a breach of Regulation 16 (Death notifications) of the of the registration regulations 2009.

- The provider failed to report safeguarding concerns such as allegations of theft, or involvement of police to CQC. This meant opportunities to seek assurances from the provider about steps being taken to protect people were missed.

This was a breach of Regulation 18 (Notification of other incidents) of the registration regulations 2009.

We discussed reporting responsibilities with the registered manager and the provider. We directed them the relevant guidance and reporting forms on the CQC website.

- People were at increased risk because many of the quality monitoring systems previously in place had lapsed. This meant the provider had not sufficiently mitigated risks relating to the health, welfare and safety of people using the service.
- The service was not following its policies and procedure. For example, gaps in recruitment, lapsed systems for monitoring staff training, staff supervision and not robustly following up staff performance concerns. Also, not completing audits. This meant opportunities to identify gaps and improve standards of care were missed.
- Where mistakes were made, the registered manager was open and honest with people and families.

Where concerns about staff were identified, they were dealt with. However, there was a lack of documentary evidence of how these were managed through training, supervision and disciplinary processes to protect people who used the service and when staff moved to other services.
● Accidents/incidents needed to be recorded more clearly and monitored, so trends and lessons learnt could be identified and shared with staff.
● During the inspection, we identified seven breaches of regulations related to safe care and treatment, good governance, recruitment, staffing including three breaches related to notifications. This showed the provider's quality monitoring systems were not effective, as these had not identified and addressed.

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

● The provider explained the previous registered manager had been responsible for quality monitoring at the service. Following their untimely loss, a replacement registered manager was appointed but they and the provider lacked experience. Since January 2019 four new managers were appointed to manage the agency, all of whom left after a short period for various reasons. This meant existing quality monitoring systems had lapsed as the registered manager and provider were so involved in the day to day running of the service.
● On the first day of the inspection, a new care manager appointed to manage the agency was undergoing induction. They had the relevant experience and was helping to re-establish quality monitoring systems.
● On 26 November 2019, the provider sent an action plan about steps being taken to address the breaches of regulations found. This including re-establishing a system for sending notifications.
●The provider planned to relocate Butterfields Home Services to another location in the New Year with the new care manager planning to register with CQC to run the agency. This would free up the existing registered manager to focus on Kingdom House.
● The agency had also appointed a quality and compliance supervisor to help with staff induction, training, supervision, spot checks, people's initial assessments and reviews of care. The provider also planned to implement electronic records in the near future which will ensure up to date care records for the agency are maintained.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and relatives gave us positive feedback about the agency. Comments included; "They are very sensitive" and "We all work together, it's really good." A social care professional said, "The feedback is good and favourable. Any problems are reported and dealt with quickly and efficiently."
● The provider was passionate about their service and the people they cared for. They said, "We provide amazing care, 100% of clients are happy. Staff are valued and well treated. What we are not doing is evidencing everything."
● Staff feedback about working at the service was positive. They praised teamwork and said they felt well supported and valued by management. Staff comments included; "I speak to [registered manager] most days. I can get hold of [registered manager/provider] if I need any advice." Staff said they appreciated their flexible working arrangements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● People and families were consulted and involved in day to day care decisions about their care and treatment. However, there were no formal systems to seek their feedback.
● The provider said staff meetings were held about every three months and were informal, so there were no

minutes to show what was discussed. This meant there was no evidence to demonstrate how staff were consulted and involved in decision making, learning lessons and continuous improvement.

● The provider worked in partnership with local care managers, GP's and other health professionals to make sure they were providing a service which was responsive to local need.

● The registered manager and provider were members of the Registered Care Providers Association and attended some local provider events. They received regular updates from the Care Quality Commission about regulatory matters.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose<br><br>The provider failed to update or notify the Care Quality Commission (CQC) of changes to their statement of purpose. This meant CQC were not aware of changes to reopen Butterfields care agency as an end of life service, so did not seek additional assurances about these changes. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services<br><br>The registered person failed to notify the Commission about the deaths of people which occurred in their own home whilst the agency was providing a service to them, as required by the regulations. This meant CQC were not aware Butterfields care agency were operating an end of life service, so did not seek additional assurances about these changes. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The registered person failed to notify the Care Quality Commission (CQC) about incidents they were required to, in accordance with the regulations. For example, abuse or allegation of abuse or any injury. This meant CQC were not aware of these, so did not seek additional information or assurances. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The agency had poor systems for assessing the risks to the health and safety of people and were not taking all reasonable to mitigate those risks. The provider had not ensured staff had the qualifications, competence, skills and experience to provide people with safe care and treatment.<br><br>Regulation 12 (1) (2) (3). |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>People were at increased risk because many of the quality monitoring systems previously in place had lapsed. There was a lack of detailed care plans and risk assessments in the domiciliary care service, which meant staff lacked sufficient guidance about how best to support people's end of life care. This meant the provider had not sufficiently mitigated risks relating to the health, welfare and safety of people using the service.<br><br>Regulation 17 (1) (2) (a) (b) (c) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>People were not fully protected from the risk of abuse because recruitment procedures were not robust enough to ensure all relevant checks were undertaken, so that the provider only employed 'fit and proper' staff. New staff started working with people before their criminal record checks were completed. Where staff had criminal record disclosures, risk assessments were not robust enough, and there was a lack additional checks to demonstrate they were suitable for the role. |

Regulation 19 (1) (2)

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>People were at increased risk of not receiving safe and effective care. This was because staff did not receive all the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their role.<br><br>Regulation 18 (2) |