Michael Batt Charitable Trust

Rushymead Residential Care Home

Inspection report

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Date of inspection visit:
30 January 2017
31 January 2017

Date of publication:
16 March 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced inspection of Rushymead Residential Care Home on 30 and 31 January 2017.

Rushymead Residential Care Home provides personal care for up to 28 people, some of whom may have dementia. At the time of our inspection there were 25 people living at the service.

There was a registered manager in post. 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 and their families told us they felt safe at Rushymead Residential Care Home. One relative told us "Mum is a lot safer here than at home, without a doubt."

Staff understood their responsibilities in relation to safeguarding people. Staff received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the authorities where concerns were identified. People received their medicine as prescribed. However, temperature checks were not always being maintained of people's medicine.

We have made a recommendation that the provider follow NICE guidance on safe storage of medicine.

People benefitted from caring relationships with the staff. Relatives commented "They (staff) care for her very well"; "Mum is in the best place, food and care is good and mum is well looked after and safe" and "Staff are all very nice and friendly". People and their relatives were involved in their care and people's independence was actively promoted. Relatives and staff told us how people's dignity was promoted.

Where risks to people had been identified, risk assessments were in place. However these did not always contain all the areas of risk.

We have made a recommendation that the provider review the safety of the use of the stair cases in the home.

Staff sought people's consent and involved them in their care where possible.

At the time of our inspection there were sufficient staff to meet people's needs. However, relatives and staff told us, at times, there were not enough staff on duty to meet people's needs. Staff rotas confirmed planned staffing levels were not always maintained. The service had recruitment procedures in place and conducted background checks to ensure staff were suitable to undertake their care role. However, there were some where references had not been obtained.

We have made a recommendation about how the dependency levels of people are calculated.

People and their families told us people had enough to eat and drink. People were given a choice of meals and their preferences were respected. People's nutritional needs were identified, monitored and managed.

Relatives told us they were confident they would be listened to and action would be taken if they raised a concern. The service had systems to assess the quality of the service provided. Systems were in place to ensure people were protected against the risks of unsafe or inappropriate care, but these were not always effective or robust.

Staff spoke positively about the support they received from the registered manager and all of the team at the home. Some of the staff received supervision and other meetings were scheduled as were annual appraisals. People, their relatives and staff told us all of the management team were approachable and there was a good level of communication within the service.

Relatives told us the team at Rushymead Residential Care Home were very friendly, responsive and mainly very well managed. Comments received included "Staff are very helpful, could not fault them". The service sought people's views and opinions and acted on them.

We found the provider was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People and their relatives told us people were safe. Staff knew how to identify potential abuse and raise concerns.

Staff and some people told us there were not always sufficient staff deployed to meet people's needs and keep them safe.

Risks to people were identified and risk assessments in place to manage the risks. Staff followed guidance relating to the management of risks.

People had their medicine as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA).

People had access to healthcare services and people's nutrition was well maintained.

Areas of the environment needed attention to ensure people's safety was maintained.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected

the decisions they made. People and their relatives were involved in their care.

The provider and staff promoted people's independence.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to moving into Rushymead Residential Care Home to ensure their needs could be met.

Care plans were personalised and gave clear guidance for staff on how to support people. People were supported in their decision about how they wished to spend their day.

Relatives knew how to raise concerns and were confident action would be taken.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a positive culture and the provider shared learning but there was not always continuous improvement.

People, their families and staff told us there was good management and leadership in the home.

The service had systems in place to monitor the quality of service but these were not effective or robust.

Rushymead Residential Care Home

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 30 and 31 January 2017 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We sought feedback from the commissioners of the service and other stakeholders.

During the inspection we spoke with four people who used the service and six relatives of people who lived at Rushymead Residential Care Home.

We looked at four people's care records, medicine administration records, six staff records and records relating to the general management of the service. We spoke with the registered manager, the general administrator, the personal assistant, five care staff, the cook, one visiting professional and one visitor.

Requires Improvement

Is the service safe?

Our findings

We looked at staffing levels in the home. Staff told us "In theory we can just about manage with six staff per shift, but less than that, we find it difficult to cope due to people's needs"; "We do as much as we can even with five care staff. Sometimes care is rushed. Agency are not always the same, so that has an impact as they need more support as they do not know the people"; "Always busy, staffing is ok if there are six care staff, if less it's (care) rushed for people"; "We have quite a few people now who have high needs and there are a few who are poorly at the moment, that's why we need six care staff. There are a high number of double ups (people requiring two care staff to move them), so we need the staff, five is not enough"; "Staffing, if six staff then yes, that's enough. Five is a bit of a nightmare and nine out of ten times, it is five staff. Although we help each other, we are rushed as need to update people's records as well"; "Staffing, each shift is different, nice if six staff on the afternoon shift, but not always possible so get them (staff) from another floor, we struggle if staff are on their own" and "Some shifts are so, so busy, most people need two care staff to assist them, so this can leave us short".

Some of the relatives we spoke with felt, at times there was a shortage of staff. Comments included "I get the impression they (staff) are rushed off their feet. There are people there with high needs who need two care staff to help mobilise them. If there are only two care staff on the floor, they can struggle" and "I know they have to use agency staff as there are different faces (staff) when I visit but mum is not left waiting for care". One visitor told us "Sometimes they are short staffed, I know of at least one person who needs a lot of care, staff are often rushed, especially in the morning".

On one occasion at our inspection on 30 January in the afternoon, we found there were no staff on the first floor and this was for a period of ten minutes. People were settled in their room, but there was one person who was walking around, the hairdresser was present and supported this person. On both days of our inspection we did not see any further evidence that there were not enough staff.

The manager told us there are usually five or six care staff on shift in the morning and afternoon and four staff members on nights. We looked at staff rotas. We saw throughout December 2016 and January 2017, there were a number of occasions when staff numbers were not maintained. For example in December there was five occasions when the rota showed three staff at night, two occasions when there was four or less on the early shift and six occasions when there was five or less on the late shift. In January it was a similar picture, six occasions when there were three night staff, five occasions when there was four staff on the early shift and eight occasions when there was four staff on the late shift.

We were told that agency staff were employed where possible to cover the shortfall. However the use of agency staff were not included on the rota. We were told by the managers' personal assistant that we could see agency usage through the invoices received. These were kept in invoice order and not date order, therefore it was difficult to confirm if staff numbers were maintained. We discussed this with the manager. They told us they had recently employed a person whose part of their role would be to monitor staffing, but unfortunately this person was not at work which had impacted on this monitoring. The provider used a dependency ratings tool to enable them to be satisfied it had the right number of staff and staff with the

appropriate skills on each shift. We also raised with the manager about people's risk assessment scores as, on some occasions, people's dependency was rated as medium risk. However, the record of staff care intervention could potentially indicate the person's assessment to be higher. The manager said they would review people's risk ratings to ensure this was correct so that they could be confident the right number of staff were on duty to meet people's needs.

We recommend the provider uses a reputable source to review the tool used to calculate people's dependency to ensure sufficient staff are in place to meet people's needs.

People and their relatives told us they were safe. Comments included; "No concerns regarding her safety" and "Yes, no concerns, they are safe".

We saw staff were aware of how to keep people safe. For example, one staff member intervened when one person was walking with their blanket. They re-directed the person back to their chair as they recognised the blanket could be a trip hazard. People had equipment to enable them to move around the home safely and staff were aware of when this equipment should be used. Staff were aware of the need to keep walkways clear, one said "We ensure we don't put anything in the way of people and we walk with people to keep them safe".

We saw the provider had checks in place to ensure people's safety. For example, records of the food temperatures and fridge temperatures were maintained by the cook. This ensured people's food was maintained at the correct temperature. Regular fire checks were carried out at the home and equipment was tested to ensure it was safe to use. One relative told us how the provider had managed their family member's safety. They told us how the provider had recognised the equipment used to move their mother was no longer effective. They said "They (staff) changed the hoist used, so mum can be moved more safely now. Another relative said "They (staff) put a mattress next to my mothers' bed to keep her safe in case she falls from her bed".

Staff had completed safeguarding vulnerable adults training. Staff we spoke with were able to tell us about the different types of abuse and the signs that might indicate abuse. Staff had a clear understanding of their responsibilities to report any concerns and were aware of which outside agencies they could report to as well as their own management team. We saw information was available for staff regarding safeguarding and this was displayed in the home and the staff rooms. Staff said, "I would report any concern and I know the numbers to call. I would make a record of what I have seen and would not be scared to report anything"; "Safeguarding is the protection of vulnerable people, we need to look after them to the best of our ability and ensure they come to no harm" and "It's looking after vulnerable people, for example, if a person's money goes missing or I see bruising on a person I would alert the team leader and the manager. I would write a report and ensure I write everything down".

Staff told us they were aware of the provider's whistle blowing policy. Whistleblowing is where someone can anonymously raise concerns about standards of care. Staff we spoke to told us they would not hesitate in whistleblowing if they suspected action was not being taken to keep people safe.

People's care plans contained risk assessments which included risks associated with: falls; nutrition; pain; medicines and use of bed rails. Where risks were identified care plans were in place to ensure risks were managed. For example, one person was assessed as at risk of falling. We were told by this person's family how the manager had taken necessary action to keep this person safe as they now had the use of a wheelchair as they were at risk of falling even with a walking frame. Staff were aware of risks to people, for example their nutrition needs as they monitored those people who were at risk of choking. One staff

member told us "I always keep an eye on people, for example, if they fall out of bed, I make sure a mattress is placed by the bed. I will check the wheelchair is in good order, people wear the correct shoes and receive their medication safely".

There were effective systems to monitor the safety of the environment and equipment. Records were accurate, complete and up to date in relation to monitoring of electrical and fire systems. There were environmental risk assessments in place which ensured people's safety was maintained. For example, we saw a risk assessment for one person who used an electric recliner chair and the garden area.

We saw that one room on the ground floor was being used as a store room. People at Rushymead Residential Care Home had open access to the room. The equipment in the room could pose a trip hazard to people. We discussed this with the manager and they told us they were in the process of moving the equipment to the basement. Staff told us this area was unlikely to be visited by people who were not escorted. This minimised the risk to people.

Systems were in place to records accidents and incidents and the manager monitored when people were involved in an incident and identified any themes, for example, when people had a fall.

Arrangements for emergencies were in place. All the people at the home had an individual personal emergency evacuation plan (PEEPS) with the exception of one person. The manager said this was an error and would add the details to the file. These were stored securely in the manager's office. We spoke with the manager and advised these ideally should be kept next to the fire panel in the reception area so that emergency staff could access these straight away.

There was a Business Continuity Plan in place. This provided guidance for staff to take in case of an unplanned emergency, for example, utility failure. The plan contained details of alternative care homes in the area, contractor details, which members of the management team should be contacted and step by step instructions for staff to follow.

Records relating to recruitment of staff mostly contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. However, we found one staff member only had one reference and another staff member's right to work in the UK had not been checked. The Personal Assistant told us they would review all staff records and obtain details where possible.

Records showed staff had completed a job application form but there were two staff records where gaps in a person's employment record was evident and the provider had not explored why this was. They told us they would check staff files. Records showed us the provider had satisfied itself staff had appropriate health checks before starting employment.

We reviewed the administration of medicines. Each floor at Rushymead Residential Care Home had its own medicine trolley which was secured to a wall and locked when not in use. Safe systems were in place to manage people's medicines. We observed the medicine round at lunchtime. Staff followed the provider's procedure and people were confident they received their medicines safely. During our inspection we saw staff encouraged people to take their medicines and were patient, supportive and did not rush people.

The provider's medicine policy was available for staff in the 'staff duty room'. This included the provider's policy for administration of people's medicine covertly where required. We were told no one in the service

had medicines administered covertly at the time of our inspection. A policy for homely remedies, PRN administration (medicines as and when required such as paracetamol for pain relief or laxatives or cough medicines) was in place. Staff told us the general administrator managed all the incoming medicine orders and disposals, for example, returns to the pharmacy. We saw the provider records confirmed receipt of medicines and disposal of medicines if they were not taken by people.

Creams for people were stored in an unlocked cupboard in the 'staff duty room'. The door to this room was not locked. We raised this with the manager, they told us they would remind staff of the need to ensure the door was locked at all times.

The provider had completed a 'how to enable me to take my medicine' document for each person at the home and these were reviewed when any changes occurred. We saw people with specific medical conditions had their medicines managed appropriately. For example, people on Warfarin or those who had diabetes. Relatives told us they believed their family member got their medicine when needed. They also said their specific needs were met. For example, they now receive their medicine in a liquid form due to their swallowing difficulties.

We saw people's medication administration records (MAR). Records were kept of when people received their medicine. These were mainly completed with the details of the administering staff member and were up to date, we found some medicine had not been signed as administered and there was no reason recorded as to why. Staff were monitoring the temperature of the medicines room and the fridge where medicines were stored, but were not recording the low and high temperature as per national guidance.

We recommend the provider ensures staff are working to the NICE guidance on monitoring medicine temperature checks of fridges and the room in which they are stored.

Requires Improvement

Is the service effective?

Our findings

The provider had systems in place to monitor staff training. They used a training matrix which showed the type of training, when it was delivered, the next due date and the next training date booked for staff.

Staff had the skills and knowledge to meet people's needs. Staff had completed training which included; moving and handling, mental capacity act (MCA), infection control and nutrition. The provider also offered staff training in addition to their core training. This included a national vocational qualification in care for level 3, blood glucose management and oral hygiene. We saw information was available for staff to remind them of their responsibilities. For example, notice boards in the staff room had the five MCA principles and safeguarding details to maintain staffs understanding.

Staff were complimentary about the training provided and were able to request any additional training they felt would improve their skills and knowledge. They told us they had received specific training to manage people's conditions. For example, dementia and this was confirmed when we viewed the training matrix. Staff comments included; "I really like it here as I can develop in the field of my choice and I am keen to improve and use my skills to help people"; "I am happy with my training"; "We have regular training, eLearning and some classroom based training, for example, manual handling" and "My training is all up to date".

New staff completed an induction and were supported by more experienced staff until they felt confident to work alone. One staff member told us they 'shadowed' another staff member before working alone.

Relatives told us they felt staff had the necessary competency to care for people. One relative said "The training is good for staff, they are professional and know what they are doing" and "They (staff) care for my family member really well".

In the Provider Information Return, they said 'they were introducing a new job role that will be of a supervisory position to compliment the team of care staff. The post holder will be responsible for overseeing, monitoring, supervising and being the main source of support and direction for the staff'. This person had started in the role, but had not been able to take up the role in full due to absence. The manager felt, once established, would make a positive impact on the staff team and people who live at the home.

We saw communication processes were in place to keep staff up to date. We sat in on a handover meeting. We saw staff discussed individual needs of people and records of these meetings where made. For example people's continence needs, mobility, equipment needed to keep people safe, fluid intake and GP visits.

Some staff had regular supervision (one to one meetings with a senior member of staff), also observational supervision. They told us it was an opportunity to discuss any concerns and development needs. Comments from staff included, "Support is absolutely fine, someone always helps"; "Support is good and I have a good relationship with the general administrator"; "I have regular supervision and I am able to have a say"; "The general assistant is really good at helping" and "I don't have regular supervisions, but I do get an annual

appraisal". We were provided with a copy of the supervision matrix. It showed some staff had supervision gaps. We discussed this with the manager, they told us the matrix was in the process of being updated and the general assistant had recognised that some staff had not received supervision as planned. There was lack of clarity of supervision for senior management as no dates were recorded on the matrix and it had 'NA' (not applicable) recorded. We spoke with the manager they said, supervisions for the senior management team was to be arranged. They would undertake the supervision of the general assistant and personal assistant and would arrange for a member of the trustees to carry out their supervision.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). 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.

We saw people's capacity had been assessed in their care plan, but these were not always recorded as specific decisions for their day to day care. We discussed this with the manager, they told us how they were working with the local authority and were making improvements to people's care plans to ensure specific decision were included. We saw some care plans had been updated with decision specific information. Care plans outlined whether people had capacity to make decisions on care and treatment, and where appropriate, a Lasting Power of Attorney was in place which had been authorised in accordance with the MCA. Where people were unable to give consent to their care and treatment, we saw consent had been obtained from their family member or appointee.

We spoke with staff about their understanding of the MCA. They told us, "The MCA is there for people who cannot make a decision and if necessary the DoLS is reviewed by the local authority"; "The MCA is there to empower and protect people, there are five principles, we need to assume capacity and decisions need to be made in the person's best interest. DoLS's is where someone is restricted and it protects their rights". This staff member knew which people had a DoLS in place at Rushymead Residential Care Home. Other staff members said "MCA is there to protect and support those who don't have capacity. DoLS is when someone is not safe to do a certain thing as they don't have capacity to make the decision" and "It's about assessing capacity to see if they can do things on their own, if not, we are there to help them".

The management team demonstrated a clear understanding of their responsibilities in relation to MCA and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made to the supervisory body where an assessment had identified the person lacked capacity to consent to the deprivation. There was a mental capacity assessment which identified the person lacked capacity to understand risks. One relative told us they were involved in the decision to make a DoLS application to the local authority for their family member. DoLS applications were kept under review to ensure that people were being supported in the least restrictive way.

We saw people's care plans included an end of life plan of care and funeral plans. It made reference to completed "Do not attempt resuscitation" (DNAR) forms which were in place for individuals. Where people did not have the capacity to make these decisions we saw professionals and staff were involved and had authorised these decisions.

We observed the lunchtime experience for people. The dining rooms were quiet as there was no background music and there was little interaction between people and staff except for when people received their meal. We were told people had made a choice of their food the previous day. Staff used the list to check people's choices. The staff members checked with people if this was still their choice and people were offered a

choice of vegetables and gravy. Staff were caring and knew people's individual needs. Tables were laid up, but there were not always napkins or condiments available for people and menus were not displayed on the table. On the second day of our inspection we saw flowers were on the dining tables. This ensured people's lunchtime experience was enhanced.

People had enough to eat and drink. Comments from people and relatives included "The food is generally ok"; "Food is adequate, cannot fault it, not really a choice"; "The food is very nice"; "My relative has pureed food and I can bring some of her favourite foods in. The kitchen will puree it for [name] and check the temperature is safe"; "Food looks lovely that people have, but it is difficult to make puree food look appealing"; "Mum does struggle with her weight, but they (home) always supplement the food with loads of cream" and "[name] has pureed food and it is very good". One relative told us they felt the food could be improved.

We saw records which showed people's nutrition was monitored. People were weighed to monitor their weight and actions were taken to address any risks.

The menu was a four week rolling programme. On the day of our visit people had the choice of cottage pie of fish cakes for their main meal. If people did not want either of the options, they were offered alternatives, for example sandwiches. Where people had a low appetite we saw staff worked very hard to find something the person would like to eat. For example, soup, milky fortified drink or two puddings. We saw people responded well to this and mostly ate something at lunchtime. One person did not eat the main meal and requested rice krispies and ice cream for afters. Their choice was respected and the person changed their mind and had pavlova instead of ice cream. People were not given a visual choice of the food. This would make it easier to choose if people had difficulty in making decisions. We spoke to the manager and they said they would look into introducing this option for people, especially those who live with dementia. At times people were left waiting for their meal as staff were required to assist people in their rooms. One staff member said "At times we are rushed". People who needed adapted cutlery were supported with the necessary equipment.

People who required support to eat their meal were supported by staff who were patient and caring. Staff mainly spoke to people as they assisted them to eat, they sat at the same level as the person, maintained eye contact, they explained what the food was and ensured people were not rushed when having their lunch. We saw people's choices were respected. Staff told us people were offered a cooked breakfast in the mornings and had other choices, for example scrambled eggs. This was confirmed when we spoke with relatives. People were able to have their lunch in a place of their choice, for example, in their own bedroom, lounge or the dining room.

We spoke with the cook. They knew people's individual preferences, including health needs and allergies. They knew people who needed their food pureed and those who's diets needed fortifying to maintain their nutritional intake, for example, add cream to custard and add butter to meals. They told us how they had recently consulted with people over what options they would like. They said they would be re introducing curry and sweet and sour dishes as a choice, including poppadum's. We saw the cook chef regularly checked fridge and freezer temperatures. This meant the chef recognised the need to keep the food for people at the right temperature and to keep people safe.

People had access to health professionals when required. People's care plans showed people had been supported to see health professionals, for example their GP. Visitors told us they were kept informed of any health concerns regarding their relative. Comments included, "They (staff) keep me updated with health problems, falls for example and any changes are documented"; "Any problems they are prompt to act and

tell me immediately of any health problems" and "I always ask when I visit. The GP also contacts me with any changes or updates". One person told us "If unwell GP comes and see me".

We noted in the home that the carpets were worn on the back staircase between the top and second floor. Some of the treads posed a trip hazard for people. We also saw that a stair rail was only present on part of the staircase. This also may cause a safety issue for people. We were told that people did not use this staircase by the manager, but one staff member told us how one person did use this staircase. The front staircase did not have any access restriction and was a spiral staircase. Both staircases did not have any treads to visually separate the carpet from the edge of the individual stair. This may pose a hazard to people in the home. On this staircase we also saw that there was no fixed banister to assist people to use the stairs. A rope rail was in place, but this did not provide a safe hand held option for people to use the stairs. We also saw the bannisters on the front stair case was low, which may also be a hazard to people. We discussed these areas with the manager and they told us they would include these works for discussion at the next trustee meeting.

We recommend that the provider review the safety of people using the stair cases at Rushymead Residential Care Home.

Staff told us one of the sluices was out of order. The manager told us the provider was aware and staff were using an alternative sluice in the building. There was a bathroom on each floor for those people who did not have an ensuite facility in their room. One of these were out of use and we were told another of the three bathrooms were not fully functional.

Good

Is the service caring?

Our findings

Relatives told us staff were caring. Comments included, "Care staff are so nice and so kind"; "They work very well with my mother, especially [staff name]": "The care staff are very caring, they do their absolute best and work very hard"; "I know mum likes the staff as she smiles at them"; "Well cared for"; "When I am visiting they still sit with mum and have a chat. I have also seen staff in the lounges and chat with people when doing the paperwork"; "I am very happy with the care, the staff are excellent, superb!" and "[name] is so happy here, I am grateful that mum can stay here".

People said "Lovely house, I am looked after well and staff are very nice"; "They (staff) are all very kind here" and "Very nice and very friendly". One professional told us on the day, "They are patient centred, do the best for the residents. They are thoughtful, know patients and caring".

Staff knew the people very well as we saw people responded to familiar staff. We saw people had names on their doors and pictures of their likes, for example, dogs. This enabled staff to strike up a meaningful conversation with people.

We saw positive interactions between people and staff. There was a jovial and relaxed atmosphere in the home and people had a banter with the staff. We saw staff were kind, respectful, very attentive and caring toward people. For example, we saw one staff member assisting a person with their medicine, they were patient, sat beside the person and explained what the tablet was for and coaxed the person to take their medicine. We also saw staff encouraged people to have conversations with them. People were dressed appropriately and staff ensured people had blankets to keep them warm.

Comments from staff included, "Staff are lovely. I don't think I could work anywhere too clinical, (staff) are natural with people here, for example, if a person wanted a cuddle, this was important to the person"; "I take time with people, it's so important"; "I always ask them before helping them as I know their needs can change daily. I ask people what colour they would like to wear that day" and "I show them clothes so that they can choose, including jewellery".

People were offered choice, for example, at lunchtime we saw several examples of how people's choice was maintained. One person only liked vegetables for their lunch with salad cream, staff knew this and ensured their preference was met. Another person did not like broccoli, their preference was sprouts and again, staff knew this and made sure their choice was met. The cook told us that another lady did not want the choice of supper one night and this lady was offered her favourite chicken soup, she was pleased and her choice was met. They also told us that they try and visit people each month to get feedback about the food.

Other examples of choice were, one person liked to go to bed late and get up early in the morning. They also wanted to wake to a Christian song. The staff sourced an appropriate radio station and ensured this played as the person woke. We saw one person who had a 'do not disturb' note on their bedroom door. We saw people were asked before staff assisted them with their care and were kind and respectful to people. Another person had their preferred name on their bedroom door. We saw people were encouraged to

choose a biscuit of their choice at coffee time and staff knew people's preference and assisted them to find the biscuit they preferred.

People's rooms were personalised, they were able to bring in their own furniture and belongings to ensure their room was homely. People told us, "I like my room as it's nice and quiet and convenient, it's adequate"; "I can go to bed and get up when I want to, no pressure and I have a choice, they are kind here" and "I have black tea, that's my choice, I can also chose what to do".

People's dignity and privacy was respected. When staff spoke about people they were respectful and they displayed genuine affection. The language used in care plans was respectful.

We saw people's confidentiality was maintained. People's care files were held securely in the lounges within the home in a locked cabinet. Staff explained how they promoted people's dignity. They said, "I keep people's doors closed, ensure they are covered when delivering personal care and that I meet their preferences, for example, a male staff member, where possible"; "I am aware that we must not write on boards in the lounges about people, also be aware you could be heard on the phone, so need to go somewhere in private and very aware I cannot divulge anything about a person over the phone"; "I know to keep the door closed for the person. I have towels ready to protect their modesty" and "I know to knock on people's doors before entering".

Staff gave us examples of how they promoted people's independence. For example, "I recognised that [name] was struggling to eat so I arranged to have some special cutlery for them, they now eat really well with these" and "I saw this person struggled to get out of their chair, so I arranged for a recliner chair which slowly raises them, this assists them to stand and now this person walks with the supervision of staff".

Relatives we spoke with told us their family member's dignity and respect was maintained. One relative said "Yes, [name] dignity and respect is definitely present".

Good

Is the service responsive?

Our findings

People were assessed prior to moving to the home and assessments were used to develop personalised care plans. Relatives told us they received details about the home when their family member moved in.

Care plans included detailed information relating to people's life histories, what and who was important to them, their likes and dislikes and there was a photograph of the person on the front of the file. Emergency contact details of family and friends was recorded along with other areas, for example, behaviour triggers or signs of when the person may become upset. The registered manager also told us how they were in the process of introducing 'All about me' books for people. The information enabled staff to know about people's past and tailor people's care to meet their specific needs. People's specific needs were recorded and acted upon. For example, one person went to bed following their lunch to rest, they would then re-join people in the lounge later in the afternoon. In the care plans we looked at we saw that comprehensive notes were maintained of people's daily care.

Mostly care plan reviews were regular, including risks and involved people or their relatives, who were encouraged to make comments or amendments to the care plan. We saw where relatives were not able to attend the annual review, a copy of the review was sent to the relative to enable them to make any comments or changes. One relative confirmed they were able to view their family member's care plan to read and make comments. Where people required further support from health professionals, this was arranged. For example, one person had been referred to the speech and language therapist due to concerns about their ability to swallow. We saw this was arranged and the appointment took place and details were well recorded for staff to follow. We saw risks to people were managed, for example, when people were at risk of losing weight. The provider used a nationally recognised tool to monitor people's nutrition. This was the 'malnutrition universal screening tool' (MUST) which determined people's risks of inadequate dietary intake. We saw people were regularly weighed to monitor this and, where appropriate, health care professionals were involved.

People's care needs were responded to. One relative told us "Definitely, mum gets the care needed here" and "They (staff) are really clued up about the care needed by [name]". One team leader told us they were responsible for two people's care plans and to ensure they were up to date and accurate. They told us "I will update the care plan regularly, daily if necessary and will review them monthly or earlier if needed. I will ensure that when a person's health changes, details are updated, for example, any choking risks or diet plans and I will involve the SALT team". This resulted in one person now receiving their food pureed. Another example was where one person had daily visits from the community nurse to administer their insulin. The staff team worked with the professional to ensure equipment was regularly calibrated and their training was up to date to ensure they could monitor the person's blood glucose.

People were supported to spend their day as they chose. There were two activity co-ordinators. We spoke with one of the activity co-ordinators and they told us how they would sit with people to get to know them, speak with families and use the information in people's care plans to maintain a person centred approach so that people do activities which interested them. We saw this co-ordinator sat with people on the day of

our inspection, they knew people well, for example their favourite biscuits and struck up conversations with people based on their past. They told us they would read poetry to people or play table games. This was confirmed when we spoke with relatives. The co-ordinator told us how they met people's individual needs. They said one lady had their religious service in private as it was their choice. One relative told us that the activity co-ordinators worked really hard with people to keep them engaged. Another relative told us that people used to go out in the summer to visit for example, garden centres, but this no longer happens. They said the trips were one of the reasons why they chose the care home. Relatives told us that they felt people would benefit from having background music in the lounges as they felt it was, at times, quiet. The manager told us they felt that people could receive more personalised activities. They had arranged for the co-ordinators to go on a course which would enhance their knowledge and how they were working to improve people's experience.

People told us "There was a good party at Christmas"; "We have a jolly time here" and "People come in and entertain us". We saw people's involvement in activities were well recorded. For example, people's choice of activity was recorded along with the outcome. We saw one person's record showed they had played dominoes and '[name] took part and was very lively and enjoyed the game'.

There was a complaints policy and procedure in place. We saw details were available for people as the policy was displayed on notice boards in the home. The manager told us they had received no complaints over the last 12 months. We saw systems were in place to record comments and complaints. Relatives told us if they had made a complaint and that it was mainly well managed, they said "Definitely speak to [managers name], and my comments are listened to, for example communication from the home" and "If I had a complaint I would speak to the manager". One visitor told us, "I have no concerns; if it did I would definitely speak up". We saw following the annual survey re care provision that one relative had made a comment that their mother had been upset by some of the care staff. The manager told us and we saw they had tried to liaise with the family on three occasions to address their comment; however, the family had declined to provide any further details. This showed the manager had tried to address a comment of concern to resolve the issue.

Staff told us they knew how to handle any concerns or complaints. They told us they would try and address people's concerns themselves. If they could not, then they would refer the person to the manager and give them details of how to make a formal complaint.

Requires Improvement

Is the service well-led?

Our findings

We examined how incidents and accidents were recorded and managed. We saw that two people had had a number of falls during December 2016 and January 2017. One person had fallen four times in December and were recorded in the person's care plan. However, when we looked at the monthly 'accident/incident report' to check they had been recorded and analysis had taken place to look for themes, this person's falls were not included. The second person had six falls in December 2016 and eight up until 18 January 2017. Again the monthly analysis did not include all the falls this person had. In one instance the person was taken to hospital as they had sustained a cut above their eye. On the first day of our inspection we saw this person and noted they also had extensive bruising to their face. We saw the care plan for this person stated their risk of falls was a medium risk and it stated 'needs a review following falls'. At the time of our inspection this review had not been recorded. We saw in December 2016 that there were two 'monthly accident/incident reports' completed. However the details were not consistent. The manager was unable to tell us why they had two forms completed and why the details of these two people's falls had not been included. We saw a monthly chart for 2016 was in place to record incidents. However, this again did not have all the details of people who had an incident. There was a graph produced, but the report did not record what action was taken. This meant there was not a robust system in place to monitor trends, look into the cause of falls and what actions had been taken to mitigate the falls occurring.

We looked at three people's care plans to see if their nutrition had been recorded correctly as they had food and fluid charts in place. We saw one person's monthly dependency score had not been completed and their weight had not been checked since October 2016. In September 2016 their weight was 68.2kg; in October 2016 it was 67.5kg, a loss of one kilo gram. Whilst we saw in this person's daily records that their food and fluid intake was good and had been recorded, it was not clear why records and reviews had not been maintained. A second person had very poor food intake and had records in place to monitor this. For the month of January 2017 we saw there were nine occasions when this person's food intake had not been recorded on their food and fluid chart. It was also not clear what amount of food or fluid this person should have as there were no totals maintained on a daily basis. In this person's care plan it said 'action plan needed', but there was no evidence of one being in place or an assessment. Although these charts had not been completed, in both cases the person's daily notes had been updated with their food and fluid intake, but these were not the main source of monitoring. On 30 January 2017 at 5pm we saw a third person's charts had not been updated throughout the day. This meant the systems that were in place to monitor people's nutrition were not robust as the document used to monitor this were not up to date or accurate. The manager told us that staff had been reminded to complete records at a previous staff meeting in October 2016; however it was not evident that improvements had been made.

Systems were in place to monitor the quality of the service. Audits carried out included: risk assessments; medicines; care plans; fire safety and the environment. However these audits were not effective or robust as they had not identified the areas of concern we found at our inspection. For example, people's food and fluid charts not being completed; mattress checks although being told were carried out, were not recorded; gaps in medication records (MARS) and temperature checks of medicine fridges not being recorded; care plans had not been audited since October 2016 and areas identified as a hazard (worn carpets) had not

been identified in the environmental audit. The manager told us they had employed a person specifically to take charge of these audits and a new personal assistant was in post to review some of the care files. However, further improvements and checks were needed to ensure safety of people and good governance is in place to provide people with good quality care.

This is a breach of Regulation 17 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

Relatives' comments on the workplace culture included; "There is an open door policy"; "I can speak to [manager] when needed and I can always get hold of them"; "Both the manager and the general assistant are 'hands on'"; "Good culture, staff appear happy"; "Overall run well, definitely the general assistant is really helpful" and "The manager has made some improvements, but needs to be more open to doing things differently and the atmosphere is not as good as it used to be, people appear to be a bit sad at times". We heard how staff were rewarded for their work with people. One relative had donated a gift and the manager told us this was shared between staff members.

Staff comments about the support included, "Support, yes it's good, if any issues, they are usually sorted quickly and professionally and explain decisions"; "I made a suggestion to change a person's care and the manager listened to me and made the changes"; "There is an open door policy here, I can speak to the manager anytime and they usually listen"; "Manager is ok, approachable and I think would listen. The general assistant is very good" and "I do love it, always a different day".

One visitor told us "The manager seems to do a good job; they are running the home ok" and "Homely and is a lovely home". One professional told us "They do well with the resources they have" and "I believe the manager is committed and strikes a good balance".

Staff told us and records showed that regular staff meetings were not always conducted. The last carers meeting took place in June 2016 and team leaders meeting was October 2016. Whilst minutes of the meetings were available, these did not demonstrate staff had the opportunity to provide feedback or discuss areas of concern. We discussed the lack of meetings with the manager, they told us they would be setting up regular meetings with staff and would circulate dates for 2017.

We saw that no resident or relatives meetings took place. One relative said "I would definitely like relative and resident meetings". Other relatives we spoke with told us they would also welcome the opportunity to share ideas and comments through meetings. Meetings would enable the manager and team to have feedback and enhance a community spirit within the home.

We saw people and relatives views were obtained about the service. We saw the results of a survey in June 2016. Information and comments were collated following the survey and action taken was recorded. For example, one question was 'do staff refer to residents as they prefer to be addressed, e.g. as Betty or Mrs Smith?', comments from one relative was 'Occasionally with a younger member of staff it would be Mrs initially', action taken was 'All staff do ask new residents what they do prefer to be called'. Whilst we can see records of these were kept, it was not clear what action had actually been taken, for example, if staff had been reminded of the need to check how people would prefer to be addressed. Positive comments were recorded on the survey; 'My relative is happy with all aspects of Rushymead' and 'Rushymead gives my relative as good as possible quality of life'.

We asked staff what it was like to work at Rushymead Residential Care Home. Staff said "I am settled here, team work is fine and I get on ok"; "I am happy here, nice atmosphere"; "Never had a problem here"; "I love it

here, if I didn't, I wouldn't stay"; "Got on with everyone, never had a problem"; I like the atmosphere and I get on with everybody"; "I think there is a good culture and it is well led"; "Good teamwork overall".

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

There were a number of improvements planned for the home. We asked the manager if there was a refurbishment plan, they said there was not but they kept a list of areas to be repaired etc. We saw invoices which demonstrated work had been undertaken to make improvements and the manager told us they were arranging further work. One staff member told us "There is no bath on the top or ground floor at the moment, so we have to give people a bed bath or a shower. There is only one bath working and some people do not like the way the bath works". We discussed this with the manager. They told us that ground floor bathrooms were awaiting a date for works. There was one bathroom available for people on the middle floor with a Jacuzzi bath and walk in shower. One person told us that the dishwasher was not working on one of the floors. The manager was unaware of this. The manager did provide us with a list of works following the inspection, but this list did not include the repair to the baths and the dishwasher repair said it was on the middle floor, when we were told it was the top floor. We noted in the family room that the glass in the door and windows was not toughened glass. The manager also told us that the family room was to have replacement doors and windows, but was unable to give us a date. These repairs were also not included on the 'job' list the manager provided us with. A refurbishment plan would enable the manager to record and monitor progress of works outstanding.

The manager told us the trustees met on a monthly basis. We were told the last meeting was in December 2016 but the minutes were not available. We saw minutes from March and July 2016. Discussions included finances and maintenance repairs. We also saw the minutes said that one trustee visits the home on a monthly basis and spoke to people. We were told by the manager these visits were not recorded. This meant it was not clear what the level of support was in place for the manager as visits were not recorded. Also it was not clear that good governance was in place, what areas they had identified for improvement and that the trustees played an active role in the running of the home. Some relatives told us they did not see the trustees and comments included "Trustees need to show more care for people in the home".

We found care staff were keen to demonstrate their practices and gave unlimited access to documents and records.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a robust quality assurance system in place to effectively monitor the safety and quality of people's care.