Embrace (England) Limited

Rushyfield Care Centre

Inspection report

Rushyfield Care Centre, Brandon Lane
Brandon
Durham
County Durham
DH7 8SH

Tel: 01913784691
Website: www.embracegroup.co.uk

Date of inspection visit:
08 March 2017
09 March 2017
10 March 2017
15 March 2017

Date of publication:
04 January 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

This inspection took place on 8, 9, 10 and 15 March 2017 and was unannounced.

Rushyfield Care Centre provides accommodation for up to 41 people who require nursing and personal care. The home is split into two units. Upstairs is known as the Usher Moor unit and downstairs is the Langley Moor unit. At the time of our inspection 19 people were living upstairs and 18 people were living on the ground floor.

At the last inspection in October and November 2015, we asked the registered provider to take action to make improvements to the administration of topical medicines (creams applied to the skin). We found the home had failed to make improvements.

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.

Visitors expressed concerns to us about the levels of staff on duty and the availability of staff to keep people safe. During this inspection we visited the home on a nightshift and found where staff were required to attend to one person this left the remainder of people unattended on the floor.

We saw staff were supported to carry out their duties through induction, supervision and training. However we found there were a number of incidents where people had not been protected and staff had not given due regard to people's well-being.

Regular checks were carried out on the building included fire-fighting equipment, fire alarms and fire drills. Water temperatures and window restrictors were also checked to make sure people were safe in their environment.

We found concerns about three people not having in place equipment to keep people safe and the maintenance of that equipment including sensor mats. During the inspection we asked the registered manager to conduct a review of everyone with equipment to ensure people were safe. The registered manager provided us with a list of 16 people for whom the service used bed or floor sensor mats, seat sensors, door sensors, crash mats and bed rails. With the exception of one person whose bed sensor was on order the registered manager gave us assurances the equipment was in place and in working order.

We also found processes to review and analyse people's accidents in the home to be ineffective in looking at people's personal safety.

Food and fluid charts were not completed appropriately in the home. There were no target fluid levels in

place so staff were not aware how much people needed to drink to remain hydrated, and we found records to indicate people had drinks after 4.30pm were not in place. The charts failed to reflect adequate food intake for people.

People and their relatives were involved in assessments of people prior to their admission to the home. Care plans have guidance to staff on how to meet people's care needs, however we found some of these care plans were missing. A resident of the day was chosen which meant their care was to be reviewed that day. We found these were incomplete and their care plans had not been reviewed. Staff were unable to provide us with audits on people's plans to ensure they were up to date and accurate.

Relatives told us about their mixed experiences of making a complaint. We saw staff had documented complaints raised by relatives but these had not been documented with outcomes by the registered manager

Activities were provided in the home by two recently employed activities coordinators. The registered manager explained the coordinators were finding out what works in the home and as yet there was no current activities programme in place.

Staff had learned the best ways to distract people at times when they became distressed. We found they engaged people in activities including singing. Staff welcomed visitors into the home.

We found staff were respectful of people and protected their privacy and dignity. People spoke to us about staff closing their curtains and doors to ensure their personal care was given in private.

The regional manager carried out monthly visits to the home and to carry out an audit on behalf of the registered provider. Over a six monthly period we found the regional manager repeatedly made the same recommendations each month to improve the service. This meant that despite the registered provider having in place a system in place to carry out monthly monitoring visits the registered manager had failed to embed the recommendations and make the required improvements.

Registered persons are required by law to notify CQC of particular incidents which occur in services. These include serious injuries to people. We found there were four notifications about serious injuries not made to CQC. Following the inspection we contacted the local safeguarding team and found further safeguarding notifications had also not been made to CQC. This meant the service had not fulfilled their registration requirements.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Details of any enforcement action taken by CQC will be detailed once appeals and representation processes have been completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found a number of regulatory breaches which meant people were at risk of unsafe care practices in the home.

Checks were carried out on the building to keep people safe.

Staff underwent robust recruitment procedures to ensure they were suitable to work with people who had chosen to live in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

During our inspection we raised concerns about staff understanding people's eating and drinking needs and ensuring people were not at risk of dehydration.

Staff received support through induction, supervision, training and appraisal.

The service adhered to the principles of the Mental Capacity Act and had made applications to the appropriate body to deprive people of their liberty and keep them safe.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff protected people's privacy and dignity.

Staff were friendly and we observed they had learned to communicate with people which prevented people in the home from becoming distressed.

We found the ability of the staff to provide good care was compromised by the absence of information about people's care need and the concerns raised by relatives regarding staffing levels.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found not everyone's care needs had been addressed by the home in there care plans.

People and their relatives had mixed responses about making complaints. We found there was a lack of joined up approach between relatives raising complaints to care staff and the registered manager monitoring complaints so they could improve the service.

The service had in place hospital passports so when people needed to go to hospital information was readily available to help medical staff with their treatment.

Is the service well-led?

Inadequate

The service was not well led.

Improvements required in the home by the regional manager were not carried out and embedded in the service.

Notifications to CQC required by law had not been made.

People's care documents were not up to date or accurate. This had been identified by the regional manager, however we found their suggested improvements had not been actioned.

Rushyfield Care Centre

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 8, 9, 10 and 15 March 2017 and was unannounced.
The inspection team consisted of three adult social care inspectors, a specialist advisor to the commission in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for people with dementia.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law.

We also contacted professionals involved in caring for people who used the service; including local authority commissioners.

Prior to the inspection we contacted the local Healthwatch. Healthwatch is the local consumer champion for health and social care services. They gave consumers a voice by collecting their views, concerns and compliments through their engagement work.

Due to concerns raised with us about the service we decided to carry out an inspection which focussed on three key questions – Is the service safe?, Is the service responsive?, Is the service well-led? After commencing the inspection we advised the registered manager and the regional manager we would be completing a comprehensive inspection.

During the inspection we reviewed seven people's care files in detail and carried out observations of people who were unable to care for themselves. We also looked at food and fluid charts for other people, medicine administration records and daily records.

We spoke with nine people who used the service and 12 of their family members and other visitors. We also spoke with 18 staff members including the regional manager, the health and safety manager, the registered manager, nurses, nurse practitioner, senior carers, care staff, kitchen staff, maintenance staff and domestic staff, and other registered managers brought into the service to carry out immediate improvements to the service.

Before the inspection, we did not ask the provider to complete 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. However we covered these areas during the inspection.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe in the home. One person said, "Yes I feel safe here and happy. There are people always around to help me." Another person said, "I am safe - always someone around to help if I need anything." One person told us, "I am safe here - I feel fine here." A relative told us, "I feel my family member is safe yes as there is care here when they need it and not just anyone can get in here, it is secure."

We observed a drugs round and found it was carried out in a professional manner. Each person was spoken to individually and the nurse dispensed the medicines in a relaxed friendly way. The drugs trolley was locked by the nurse each time they went to dispense a person's medicines. We checked the stocks of medicines and found fridges which were full of medicine stocks.

We saw there were fridge temperatures charts in place; however these were not recorded daily. The nurse on duty explained the gaps by stating it had been an agency nurse on duty at the time. The temperatures recorded were within the required ranges, there was no evidence to suggest temperatures recorded compromised the integrity of the medicines.

We found some people's prescribed supplements had a best before date of January 2017. These were stored at the back of a fridge. We looked in the fridge in the clinic room and found the newest dietary supplements were stored at the front of the fridge, and stock had not been appropriately rotated. The issue was raised with the nurse on duty who agreed to tidy the fridge and remove the supplements which were beyond their best before date.

We found medicines on top of the fridge. The nurse on duty described the medicines on top of the fridge as "Old medicines" and belonging to people who had passed away. The NICE guidelines state, "Care home providers should keep records of medicines (including controlled drugs) that have been disposed of, or are waiting for disposal. Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy." We found the medicines were not stored in line with NICE guidance.

During our last inspection in October and November 2015 we found the provider did not have in place suitable arrangements to manage people's topical medicines (creams applied to skin). During this inspection we found the service had failed to make improvements in their arrangements. We found the registered provider had in place guidance for staff entitled, "Embrace, Best Practice Guidelines: Administration of Topical Medication" dated July 2015. We saw people's topical medicines were stored in their rooms in unlocked drawers which was contrary to the registered provider's guidance, and we found staff were not given suitable guidance on when to apply the creams. From October 2016 the regional manager in their monthly reports had given advice to the service to improve the administration of topical medicines. This meant people were at risk of staff administering their topical medicines in the wrong way.

We looked at the Medicine Administration Records (MAR) and found people needed medicines known as PRN. These are medicines which people require on an 'as and when' basis. We found in one clinic room four

people required PRN topical medicines or medicine for constipation. Guidance was not provided to staff using a PRN plan. This again placed people at risk of staff administering their medicines inappropriately.

One relative told us, "It is a safe as it can be - but it all comes down to staffing for safety and I do not think there is enough staff here at all. There is a very high turnover of staff as well." Another relative said, "I am in everyday and there is never any staff in the lounge. People are just left in there. Sometimes it is up to an hour before I see a staff member come in. It is a worry - especially if my family member is in there. I did speak about this as well and it changed for about a week and then it stopped." Visitors to the home told us sometimes they helped with people if staff were busy. Another relative said, "I have mentioned my concerns over only having two staff (on the residential unit) in the evening and the (registered) manager said they will change that and it never has - it really is a worry."

A member of staff told us, "I enjoy my job it is a lovely home in itself but I really think we need more staff downstairs days and nights and over lunchtimes. There are nine feeds (people who need support to eat) downstairs and it is very hard to manage." We looked at staffing levels in the home. Staff told us they were concerned about the levels of staff on a nightshift due to the number of people living in the home who were highly dependent on staff for support. Staff expressed their concerns to us that if one person required two staff to attend to their needs this often left the remainder of people without supervision and support. During our inspection we found one person had an accident and called for staff attention. Two staff members and the nurse were required to give the person attention which left the remainder of people on the floor without support. We saw in the minutes of the health and safety meeting held in January 2017 this issue was raised by staff. This meant there were insufficient staff on duty to meet people's needs.

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

All staff we spoke with told us that they had received training in safeguarding people and that they would feel confident to report anything which concerned them to the registered manager immediately without hesitation. We saw staff had completed safeguarding training. However we found a number of omissions in the home where people had not been provided with safe care.

Prior to the inspection information came to our attention of equipment not being provided to a person who had suffered a significant injury. During our inspection on a night time the inspectors found a person on the floor without the protective equipment they should have had in place. We saw in a staff handover note a staff member had asked the day shift to replace a battery in a person's sensor alarm. Other staff told us batteries were available in the clinic. This meant one person did not have a fully operational sensor mat in place until the battery could be changed by a staff member who was aware where the batteries were stored.

We asked the registered manager to carry out a review of equipment used in the home. The registered manager gave us a list of 16 people for whom the service used bed or floor sensor mats, seat sensors, door sensors, crash mats and bed rails. The registered manager told us one person's equipment was on order and provided assurances the equipment used to support people was in place and in working order. We also noted one person had lost significant weight and asked the registered manager about it. They told us staff were using the weighing scales in different parts of the building which affected the readings. We asked when the scales had last been calibrated; the registered manager was unable to tell us. The regional manager told us they would arrange for the scales to be recalibrated. All this meant people in the home were at risk of the inappropriate management of equipment.

We found tables in the dining room had not been cleaned from breakfast and at 11.45am the placemats

were still dirty and were encrusted with food. We saw the service had in place mattress audits to check if people's mattresses were clean. We found one person's mattress was dirty and asked for it to be changed. The registered manager advised us the mattress had been changed; we checked the mattress and found this to be the case. We also saw in the clinic room medicines pots were left drying on a radiator and one person's false teeth were also on top of the same radiator. This meant people were at risk from unsafe infection control practices.

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

In the service user guide we read, "Rushyfield has a comprehensive set of risk assessments and all accidents and incidents are recorded, followed up, analysed and action taken." We checked to see if the service carried out these actions. We found the home had risk assessments in place for the building and action had been put in place to mitigate the risks to people in the home. We found a number of accidents forms which had not been seen by the registered manager and included in their audits. We spoke with the registered manager and the regional manager and learned the registered provider had introduced a new electronic system which failed to identify if individual people had a number of falls. We later spoke with the health and safety manager who confirmed the system was not good at looking at individuals. The registered manager had relied on the new system and had not audited the fall trends in the home to protect individual people. The registered manager was unable to track people who were at risk of having a number of falls across different periods of time. Following the inspection the registered provider advised us the electronic system was not intended to be used for analysing accident trends, and the onus was on the registered manager to continue to monitor accidents in respect of individuals. During the inspection the registered manager told us they had not done this since June 2016 when the new system was implemented. This meant systems and processes were not established in the home and operated effectively to assess, monitor and improve the safety of the service.

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

The service had in place regular checks to test fire equipment including fire doors, alarms and fire extinguishers. Hot water temperature checks were regularly carried out for bedrooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). Window restrictors were in place to prevent people from falling out of their bedroom window; these were also checked on a regular basis. This meant checks were carried out to ensure that people who used the service were in a safe environment.

People had in place 'Personal Emergency Evacuation Plans' which were accessible for emergency services and helped them understand how people needed to be evacuated from the building.

The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helped employers make safer recruiting decisions and also prevented unsuitable people from working with children and vulnerable adults. We saw the registered provider had used the DBS service to carry out checks on staff before they started working in the service. We also saw they required prospective staff to complete an application form detailing their previous experience and training, as well as providing the names of two referees. The service had taken up the references to check staff member's suitability for the role.

In the staff room, we observed there were notices about safeguarding and a whistle-blowing policy

displayed on the wall for all staff to see. The registered manager told us on the day of inspection there were no current or on-going whistle blowing investigations.

We saw the registered provider had in place a disciplinary policy to protect people who used the service from unsafe staff practices. We found the registered provider had used the policy to address unacceptable staff practices

Requires Improvement

Is the service effective?

Our findings

We checked to see if people living in the home received enough food and fluids. We asked a staff member if there was a mid-morning drinks trolley and overheard them later telling their colleague they would have to get a drinks trolley out because they had told us one was available each morning. It was observed that tea, coffee, and biscuits were not visibly offered at 11am on a trolley, However we found there were crisps biscuits chocolate buttons and bowls of fruit in the lounges. We also saw large bottles of diluted blackcurrant juice which we found were heavy to lift and pour. We saw staff brought through bowls of fruit in the morning to the lounges. We were told by most of the relatives that this was not usual at all in the lounge and they had never ever seen that before and they come to visit their family members daily. One relative said, "The lounge is full of stuff i.e. the fruit bowls and chocolate, crisps extra juice that is seriously not normally there and there is also hardly ever any staff in the lounge and there are today. It is because you (CQC inspectors) are here today." Another relative said, "I am here every day and I have never ever seen fresh flowers and the fruit bowls and snacks and chocolate that they have out today before, also there is never any staff manning the lounges like there is today. It must be because you are here today. Also, all the cushions are new as well they were replaced a few days ago." This meant we could not be reassured people were routinely given drinks and snacks to reduce the risks of dehydration and malnutrition.

Following the inspection the registered provider told us they had purchased the cushions prior to our inspection and that the snacks are purchased as a complementary service.

We reviewed food and fluid charts for people to see if they were receiving enough food and fluid to sustain them. The charts indicated people had not been offered fluids after 4.30pm. The regional manager in their monthly visits to the home had repeatedly requested the charts be completed over each 24 hour period.

We found people who were losing weight and their food and fluid charts failed to indicate they were receiving sufficient nutrition and hydration. For example on some charts it was recorded people needed to have three meals per day and snacks, however the charts did not demonstrate this was occurring. During our inspection we found two people had been admitted to hospital with dehydration and found on discharge back to the home staff had failed to appropriately monitor their fluid intake.

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

Catering staff explained to us about their knowledge of people's diets and which person was on which diet. For example the catering staff knew who had diabetes and who required a soft or pureed diet. They explained to us that nearly all the food they produced was fortified with additional calories to prevent people losing weight. We found following a visit to the home a professional had recommended one person have a high protein diet. This had not been passed onto the catering staff and we drew this to the attention of the registered manager and the regional manager for their action.

We found there were different methods of communication in the home. There were handover notes in place

between each shift on each floor. The staff alerted the next shift to tasks required, however there were no indications that the required tasks had been carried out. People were described on the handover notes by their room number. Handover books were in place for staff to remind each other of events. Each morning at 10am there was a morning meeting where heads of departments met to provide information about their day ahead; this included for example if there were to be any maintenance visits to the home or what activities were to be carried out that day.

People spoke to us about the food and said, "The food is nice I like it", "The food is ok not brilliant but not bad" and "I like the food - there is always plenty." One person said, "The food is not really my kind of food, I don't feel there is much choice to be honest. It would be nice to have options. I eat in my room sometimes and I also sit in the dining room as well it depends how I feel as it can be noisy in there." Relatives also spoke to us about the food. One relative said, "The food seems good I have seen it, my family seems to enjoy it and has not had any complaints." Other relatives said, "The food is good my family member enjoys it" and "The food is fine here, my family member doesn't eat much but they seem to enjoy what they have."

We saw the service had in place relationships with other healthcare providers including GPs, community nurses, tissue viability nurses, opticians, chiropodists.

We looked at three staff files and found staff who had started working in the service received an induction. Staff without a background in care services were required to complete the Care Certificate. The certificate is a nationally recognised qualification which set out standards of care to be provided. The registered provider had in place an e-learning framework. We saw staff had undertaken the e-learning programme including the learning identified as the registered provider as mandatory. This included safeguarding, basic life support, dementia and infection control. Due to the findings of the inspection the regional manager told us they had arranged for training for the staff in nutrition and hydration.

Staff also received supervision and appraisals from their line manager. Supervision is a meeting between a staff member and their line manager usually held to discuss their progress, training needs and any concerns the staff member may have. The registered manager showed us their supervision matrix which showed us staff had been receiving regular supervision. We saw the notes from the supervision meetings in staff files.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are 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 were being met." We saw the home had made applications to the relevant authority to deprive people of their liberty and had informed CQC about doing this. Staff were trained in the MCA and DoLS. Consent was obtained from people or their representatives if people did not have the capacity to consent themselves.

We saw the home had added pictures and murals since our last inspection to provide themed corridors. We chatted to people about the pictures of a sweetshop. One person said, "They are not real you know." We found the home had improved people's environment. In the residents' and relatives' meeting held in

November 2016 the registered manager spoke about further improvements to the home.

Requires Improvement

Is the service caring?

Our findings

We spoke with people and their visitors about the care they received. One person said, "I am happy here the staff look after me." Other people told us, "The staff are lovely, they help when I ask for it" and "The staff are fine, there if I need anything." A relative told us, "There are a few staff members that are outstanding and the rest are just ok. They need some more staff." Another relative spoke to us about feeling upset when staff had commented on the behaviour of their family member. They expressed concern to us about the staff understanding dementia and felt they needed to be sympathetic to relatives.

Staff had developed a good understanding of people's needs and how best to communicate with each person. For example, it was observed in the dining room that one person was banging their fists on the table quite loudly and shouting. Staff handled this well and they bent down and gently held hands with the person and started moving them around as if they were dancing and started singing a song and then said "Lunch won't be long ". They advised that the person always does that when they must wait for anything and the key is to distract them and keep them calm.

We saw the registered manager had addressed the issue of dignity in the October staff meeting and advised staff of what was not acceptable. However we found one person who was in the dining room unsupervised had removed their clothing and was walking around naked. This type of incident had been reported to us prior to the inspection. In the absence of staff we drew this to the attention of the registered manager.

We found aspects of the service which were not respectful towards people. Staff referred to people on the handover sheets by their room numbers, for example, "[Room number] tea-cereal given" and [Room number] agitated since lunch time." We found staff spoke about the people who were known as "Feeds". These were people who needed support to eat. Staff also spoke to us about, "Doublers." These were people who needed two staff to support the. We found the service had developed a language in describing people which was not respectful towards individuals.

We observed that staff were very friendly and appeared to have a good relationship with the residents and family members. Staff welcomed relatives into the home and knew them by name. For example, a staff member was holding hands and singing walking along with someone who did not know where they wanted to be. The person was comforted and was very at ease in the company of the staff member. This meant staff used distraction techniques to promote people's well-being.

Everyone we spoke with told us if they needed any help with personal care, bathing, or other assistance they felt very respected and told us any curtains were always pulled across or doors closed for privacy and dignity. We were told members of staff always knocked on rooms doors first and asked permission before entering or assisting people.

We saw people were free to choose their own religious beliefs. These were documented in people's care plans and written in a respectful way. Staff were given guidance on how to care for one person with specific beliefs which meant their well-being was protected.

Relatives told us they felt involved in making choices and decisions about their family member's care. One relative said, "The staff let me know how [person's name] is doing so I can plan what I'm going to do so [they] can get the most out of my visits. Another relative said, "Communication is good and I make sure I feed back to them they also help me with anything or any questions I have. We saw residents and relatives were invited to meetings. At the last meeting in November only two relatives attended.

Staff promoted people's independence, for example we observed staff give people the opportunity to go to the dining room. One member of staff said, "Are you ready to come down to the dining room for your lunch? Here is your frame, that's it take your time." We observed laughter and joking in the dining room which provided a pleasant atmosphere.

We were told by all the people we asked that they could go to bed and get up when they wanted. Most people advised us they liked to go to bed quite early, a few advised they liked to go around 10pm. One relative asked at the last relatives' meeting about if there was a set bed time as they thought it was too early. The registered manager advised there was no set bedtime and it was up to the individual person when they wished to go to bed.

We saw people's rooms were personalised with items they had brought from their own homes including ornaments and photographs. This meant people had familiar things around them to support them and make them feel at home.

We observed staff supporting people in a safe and caring manner. Staff moved people safely and ensured people's foot rests were always in use before supporting them to get around in their wheel chairs. They explained to people what they needed to do. This meant the risk of people's feet getting trapped under the chair was reduced by staff acting in a caring manner. We saw in shift handover notes staff advised each other how to support one person to avoid them sitting on a chair foot rest.

We looked at people's end of life care records. People had in place, "Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documents, which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). People had in place end of life care plans, although not everyone's was up to date.

We found letters to people in the back of a notebook used to pass information between staff. Staff had written in the notebook on 9 February 2017 that the letters had been found in a drawer. This meant people's personal mail had not been delivered to them and not been treated with confidentiality.

We found staff were providing care to people to the best of their ability using their knowledge of people. However we found their care giving was compromised by the lack of care planning, the concerns raised by visitors regarding staffing levels and the culture of the home.

We saw the home had a menu board on the wall with a picture of the meals to give people information about the meal options available. As we were looking at the boards a visitor to the home told us, "They are never right". For one lunch time period we saw the menu board showed there was mince and dumplings or chicken and mushroom pie with mash or chips turnips and peas. The desert was coconut tart and custard. We saw the actual lunch choices were macaroni cheese or sausage and mash or chips with peas. The dessert was spotted dick and custard. Similarly at tea time the meal was listed as spiced parsnip soup, hot dogs and onions in a bun, lemon cake and fruit cake. The actual meal brought from the kitchen was vegetable broth, a selection of sandwiches chocolate mousse and mini chocolate eclairs. This meant systems in the home to support people were not being effectively used.

Requires Improvement

Is the service responsive?

Our findings

Prior to admission to the home we saw people were assessed to see if the home could meet their needs. However we found their needs, once assessed did not always lead to sustained actions being carried out. For example safety equipment was not always available and people's topical medicines not always applied. This meant whilst the home had identified risks, the actions required to provide safe care were not always carried out.

We found two people at risk of dehydration and care plans with actions had not been put in place to reduce the risks of future dehydration and prevent any further admissions to hospital.

We saw staff weighed people and found two people who had lost weight. We found there was not a direct link between staff weighing people and the use of the Malnutrition Universal Screening Tool. This meant staff were not able to see if a person losing weight required subsequent actions and monitoring. We found actions were not in place for the two people who had lost weight. We drew to the attention of the registered manager the person who had lost a significant amount of weight. They requested staff re-weigh the person and a discussion took place with a local health practitioner who agreed a referral to a dietician was required. This meant staff were not identifying issues which should have resulted in actions being taken.

We found one person with diabetes and asked to see their blood monitoring as described in their care plans. We were told this was not in place as the person was stable. However there was no evidence to demonstrate this was accurate. We drew this to the attention of the registered manager and the regional manager.

All this meant the home had failed to ensure care and treatment was provided in a safe way for people who used the service.

We saw staff had carried out reviews of people's care plans. The service had in place a "Resident of the Day" which meant one person was chosen each day to have their plans reviewed. However we found this had not taken place. The regional manager told us this was not as embedded in Rushyfield Care Centre as in other homes. We saw in the regional manager's report on the home in December 2016 they had stated the initiative was, "In place but can be sporadic" and was, "To be refocused from 1st January 2017." We found this had not been achieved.

During our inspection we found two people who had been discharged from hospital and saw their discharge notes were not always followed up with continued care in the home. For example one person's end of life care plan was not put in place. In another person's care file we found they had experienced seizures, however there was no seizure plan in place. This meant people were put at risk of receiving inappropriate care.

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

We reviewed seven people's care plans and saw people had in place a document entitled, "This Is Me". This document provided an at a glance summary of people's background and their needs. We found people had care plans which described people's needs to staff. For example we saw one person's communication care plan advised staff to speak in short sentences so the person could better understand what was being said. In another's person's plan we saw how they liked to be sociable and preferred to be in the company of others.

We looked at people's daily notes and found staff routinely recorded after each meal each person's mealtime experience. However we found the daily notes did not reflect people's needs as described in their plans. In their monthly visits to the home the regional manager had repeatedly required improvement in the daily notes and required staff to record, for example, visits by relatives. The registered manager had failed to embed the improvements required in the daily notes. The regional manager told us they had recently completed a review for the registered provider of the daily activities record and had designed new paperwork which would reduce the number of entries staff had to make but improve the quality.

We spoke with people and their relatives about their experience of making a complaint. People we spoke with advised that they did not know how to make an official complaint but if they had a problem would be comfortable to speak to staff or the registered manager. One relative told us staff were not effective in resolving complaints but the registered manager was more effective. Another relative told us they had complained about their relative wearing other people's clothing which was too small for them. They spoke to the registered manager and were told it would not happen again, only to find that it did happen again. We found people and their relatives had mixed experiences of making a complaint or raising a concern.

We looked at the complaints file and found since January there had been one complaint recorded. The registered manager told us complaints made earlier in January had been put into the archives. We saw the registered manager had recorded the complaint, it had been investigated and a response provided to the complainant. In the service user guide we found people who used the service and their relatives were advised to speak to the care staff in the first instance to try to resolve their concerns. We saw from recent handover sheets one family had complained about transport not being booked. On another handover sheet written in the complaints box a relative had asked they be informed of any of their family member's hospital admissions. This meant staff were responding to the issues raised by relatives and sharing the information required with colleagues. However we found these complaints were not documented in the complaints file for the registered manager or registered provider to review. This meant the handover notes were being used to document concerns and complaints made to the staff but there failed to be a joined up approach with the registered provider's complaints process. This meant the registered manager did not have systems and processes in place to monitor and improve the service.

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

The registered manager told us activities in the home were being run by two new activities coordinators who had recently been employed. We found there was not a programme of activities in the home. The registered manager told us the activities coordinators were just "Finding their feet" and were learning what worked best for people using the service. We saw the activities coordinators attended the morning meeting and spoke about the activities for that day; these included spending time with people on a 1:1 basis. At our last inspection we saw staff had been trained in OOMPH (Our organisation makes people happy). This is a movement to music programme using for example pompoms. We observed 10 people in the lounge sitting and participating with the OOMPH programme. Everyone seemed to be enjoying it.

The registered manager spoke to us about other activities brought into the home including a voluntary

service to get people involved in crafts. A hairdresser visited the home every week.

We saw the home had in place hospital passports. These are prepared documents which gave details about a person's background, their medical history and current medical needs. They are used when a person needs to go to hospital to enable the medical staff to have information about each person.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in the service. They had been registered with CQC in January 2016. We spoke with relatives about the registered manager. One relative told us, "The (registered) manager is a lovely person and think they do try but nothing gets done about anything." Another relative said, "You can complain and the (registered) manager is nice and says they will act on it but never does." Other relatives said, "I do not feel listened to at all. Nothing gets done about anything. I feel the (registered) manager is not good at all", and "We have not had a relative meeting for a few months either - think next one is 22 March. I voice any opinions but I don't feel listened to."

We spoke with staff about the registered manager, they told us they did not feel supported by the registered manager particularly over issues to do with staffing. Staff told us they wanted the registered manager to be more hands on and understand the levels of care people needed.

We looked at the accident records for people who had sustained serious injuries in the last six months and compared these with the notifications sent to CQC. Registered persons are required to submit notifications to CQC by law where a person receiving care and treatment in a service sustains a serious injury. We found four serious injuries in the service where CQC had not received the appropriate notifications. This meant the registered person's for the service had failed to meet their regulatory requirements. Information provided by the local authority safeguarding team following the inspection showed further notifications had not been submitted on the issue of safeguarding.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We reviewed the regional manager's visits to the home between October 2016 and February 2017 and found the regional manager had repeatedly highlighted the same improvements to the home and had listed several "To do" actions on each file to ensure the files were completed, accurate and up to date. For example we found in October, November, January and February they had commented on the actions required to ensure food and fluid charts were up to date and people were not at risk of dehydration. We looked at people's daily records and found food and fluid charts had not been fully completed. We found mid-afternoon and end of the day summaries were not completed. This meant that despite the regional manager identifying the improvements, records continued to remain in accurate.

Similarly the regional manager had identified gaps in people's records, required personal documentation to be completed and care plans put in place. We found some care plans were not available to guide staff on what actions to take. The regional manager had also identified in their reports instructions to improve the recording of people's topical medicines and updating daily menus for people. Deadlines had been set to make improvements, but we found they had not been met. This meant the registered provider's visits had not resulted in improvements to the service.

During the inspection we asked the registered manager to provide us with audits of people's care plans. None of the staff in the home were able to demonstrate to us that care plan audits had taken place. This

meant systems and processes in the home failed to ensure people's care files were audited to improve, monitor and assess the quality of the service provided in order to carry on the regulated activity.

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

Registered persons have a duty of candour. This means they are required to act in an open and transparent way to inform and advise other agencies in relation to care and treatment provided to people who use the service. We found the duty of candour had not been met in the service. For example where people had been found to be a risk in the service safeguarding alerts had not been made to the local authority.

We looked at the culture of the home. One member of staff told us there was no team approach to meeting people's needs. We found whilst staff were finding issues these were not carried through. For example staff found people's letters in a drawer, put a note in a book and they were left. One person lost a significant amount of weight but there was no action in place. When we raised this with the registered manager and the regional manager, the regional manager stated they would arrange for the scales to be calibrated. Staff had received complaints about the service from relatives, written them on the handover record but this had not been addressed by the registered manager. We did not find an open, accountable, pro-active and joined up approach to people's care needs.

During our inspection we observed professionals visiting the home and saw staff engaged with them and gave them relevant information about people's needs. We found the home had engaged with other professionals to meet people's needs including the Speech and Language Therapy (SALT) team.

We found when audits had been delegated to staff these had been carried out on a regular basis. For example kitchen audits and health and safety audits were completed monthly.

The registered manager sent us copies of recent minutes of meetings they had chaired. This included staff meetings and the minutes of the health and safety meeting. We saw the registered manager had responded to staff concerns in the meeting.

The service had an up to date statement of purpose, this is a document which tells people and their relatives what they can expect from the service.

We saw the home had carried out surveys to measure the quality of the service. These were displayed on the wall and were largely positive. The regional manager told us new surveys had recently been sent out. Following our inspection the regional manager advised us of actions they would take in surveys to get a more accurate picture of the home.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of incidents which occurred whilst services were being provided in the carrying on of a regulated activity,

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed in a safe manner. The provider had failed to do all that was reasonably practicable to mitigate any such risks

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people who used the service were not being met.

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess, monitor and mitigate the risks to people who used the service.

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staff on a night time.

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made.