Care Quality Commission

Embrace (England) Limited

Rushyfield Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 4 and 14 November 2014 and was unannounced. We last inspected this service 15 April 2014 and found the service to be compliant.

Rushyfield Care Centre is a purpose built facility that provides care for up to 41 people with dementia type conditions. The service is on two floors; the ground floor provides residential care and the first floor provides nursing care.

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. At the time of our inspection there was a new manager in post who was applying to become registered.

During our inspection we found the staff were caring towards people who lived in the home. The relatives we spoke to were unanimous in their praise that staff were caring and one resident said "It's always nice here."

We observed staff treated people with dignity and respect and closed their bedroom doors when they delivered

Summary of findings

personal care. Staff talked to us about the people they cared for and told us about people's likes and dislikes. They spoke about people warmly and gave us information about their past to indicate they knew about the people they were caring for.

We looked at staff recruitment records and found the provider ensured staff who had been recruited were fit to care for vulnerable people and had the required experience and ability to care for people.

We found the provider had taken the decision to reduce the number of care staff and the care staff told us there was insufficient staff to safely care for people. We found on some days there was a mismatch between the numbers of staff on the rotas and those who had signed in. This meant there was not enough staff to care for people.

We found supervision and support to staff was not consistently delivered. Some staff needed to complete training.

In circumstances where people needed to have their fluid intake measured we saw there was no expected level of intake recorded in line with any care plans. We found that differing fluid intake amounts did not trigger any action on the daily recording sheets or changes in people's care plans.

We saw the provider had responded to the complainant within three working days to acknowledge their complaint and responses had been provided in writing. We found people could be confident if they made a complaint that it would be responded to.

We looked at people's behaviour charts and found staff were not recording outcomes and interventions to enable staff to learn about what works when responding to people.

One relative told us, "The manager has implemented some positive changes." Another relative we spoke to commented that they liked the new manager and was of the opinion that the service was beginning to improve under her leadership, stating "She's got a grip".

We saw the regional manager visited the home each month and carried out quality checks. Actions were then listed for the manager to carry out with deadlines to improve the service. At the time of our inspection there were a number of actions outstanding.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 You can see what action we took at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found arrangements were not in place to ensure there was sufficient staff on duty to keep people safe.

We saw the provider had in place arrangements to undertake appropriate checks on people before they were employed. This meant people were supported by staff who had been checked to see if they had the skills, experience and were safe to work with vulnerable people.

We found the home required further cleaning to reduce the risk of cross infection.

We looked at five people's care records including their care plans, risk assessments and daily notes. People had been assessed prior to living at Rushyfield to see if the home could meet their needs. We found the care records accurately reflected people's needs.

Is the service effective?

Requires Improvement

The service was not always effective

We found that people's nutritional needs were met.

However where staff recorded people's intake of fluid we found changes to people's fluid intake did not trigger any action in people's care plans. We found this monitoring to be ineffective.

We found supervision and support was not being consistently delivered to all staff.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us the service was caring.

In our observations we noted staff treated people with dignity and respect. We saw people's room doors were kept closed when people were being supported with their personal care.

Staff talked to us about the people they cared for and told us about people's likes and dislikes. They spoke about people warmly and gave us information about their past to indicate they knew about the people they were caring for.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found people could be confident if they made a complaint that it would be responded to by the manager.

Summary of findings

We saw the service was not recording outcomes and interventions when they worked with people who challenged the service. This meant other staff were not learning about what works when responding to a person.

We found the service reviewed people's care needs and made changes to care plans when required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People told us they felt the new manager had taken charge and made some positive changes.

We found the service was monitored on a monthly basis by the regional manager. This meant the provider was assessing and monitoring improvements to the service.

We saw the manager had not completed monthly service audits. This meant monitoring to check to see if the service was meeting regulatory standards had not been carried out.

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 4 and 14 November 2014 and was unannounced

The inspection team consisted of two adult social care inspectors and a specialist advisor to the Care Quality Commission. The specialist advisor had a background in care services for people with dementia type conditions.

Before the inspection we reviewed information we had gathered including notifications sent to us by the service. We also looked at information provided in six telephone calls made to the Commission by whistle blowers who wanted to tell us about the concerns they found in the service.

During the inspection we spoke to four people who used the service and five of their relatives. We also spoke to ten staff members including kitchen and laundry staff, nursing and care staff, activities coordinators and the manager. We pathway tracked three people's care records and looked at the care records for a further two people. We also checked medication administration records (MAR) on one floor and separate wound records for eight people. We observed the care given to people by staff. We looked at staff rotas and documentation appertaining to the running of the service.

Requires Improvement

Is the service safe?

Our findings

We reviewed six contacts with the CQC where people blew the whistle on Rushyfield and told us they were concerned about the lack of staff on duty which they thought was putting people at risk. They told us about incidents where if a member of care staff had to go to hospital during the night this would leave one carer to look after people on one floor. One member of staff told us on a nightshift, "There should be two carers and a nurse upstairs and two carers downstairs, one of which would usually be senior carer." The manager agreed with this viewpoint but attributed the shortness of staff to staff ringing in sick at the last minute and the manager was unable to find cover. Another member of staff told us the service would benefit from an extra member of staff at times of the day when people required 2:1 care. Staff told us people were "Sometimes" kept waiting for attention.

We compared the staff signing in book for fire purposes, the rota and the thumbprint recognition system linked to the staff member's pay roll for the night time shifts in October 2014. On Saturday 4 October 2014 and Saturday 18 October 2014 we saw there were two care staff and an agency nurse on night duty. On both nights two care staff had declared themselves sick. One whistle blower told us sometimes there is one staff member on the upstairs unit and people cannot get to bed for a reasonable time and people are left sat there because they have to get round so many. They went on to tell us there are people who require two carers, so they have to wait until the one staff member who is working downstairs can come up to assist. We found with so few staff on duty there were risks to people not getting the right care.

We found on 26 October 2014 three care staff were on the rota to work, no one signed the fire register and only one member of staff signed in using their thumb print ID. We could not be assured that there were sufficient staff on duty to care for people that night.

We looked at the minutes of a staff meeting held in October 2014 and saw the manager told the staff from the next day staff would be reduced to one nurse and one carer downstairs and one senior carer and one carer downstairs. This meeting was prior to our inspection and was different to what we had been told. On the morning of our first day of inspection we arrived early to find one carer had been required to take a person to hospital during the night leaving two carers and an agency nurse behind to care for 35 people. We found the rota did not provide capacity to respond to emergencies.

We spoke to staff about who required two staff members to care for them; staff were able to give us a list of eleven people who required 2:1 care. One person said, "The worst night when I was working on my own". They told us when a nurse comes on duty they are focussed on ensuring people have their medicines, but when a carer comes on duty they are focussed on ensuring people are turned in their beds to avoid pressure sores developing. One staff member told us there were three people who required turning every two hours during the night. The staff member told us due to a lack of staff they have sometimes changed the bed position of the person as there was not enough staff to safely turn people in their beds. Staff also described to us people who became agitated during the night and required staff attention often taking time away from other people. Another member of staff told us if the home receives a crisis admission this reduced the ability staff have to care for people as one member of staff is needed to support the admission. This meant people's care was at risk of not being appropriately delivered.

One relative told us there was often not enough staff on duty and on occasions it is the visitors that make the afternoon beverages for the residents. But the relative also stated that "You can't fault the staff, they do a difficult job". Despite the identified shortcomings by the relative they told us they had "A lot of confidence in the place". Another relative told us, "Staff often feel stressed and tense, rushing around." These views were also shared by another relative spoken to, who was concerned about the lack of staff "There is not enough staff floating about and available in the lounge and communal area."

We spoke to the manager about the perceptions of relatives, she told us a number of staff had recently left the service and they had recruited new staff including nurses and bank workers. They showed us the rota's going forward and how there was more staff on the rota.

We found the provider did not at times have sufficient staff on duty to ensure people were safe. We found there was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service safe?

During our inspection we looked to see if staff had been safely recruited to work with vulnerable people. We saw staff completed an application form and were expected to document their previous experience. The manager explained she checked for any gaps in employment so staff were accountable for their time between jobs. We saw the provider had asked for two references and had undertaken a Disclosure and Barring Check (DBS) to make sure they were fit to work with vulnerable people. We asked the manager if anyone's DBS check highlighted they had committed a previous offence what action would be taken. The manager showed us a risk assessment where one person had committed an offence and the provider risk assessed if they were suitable to work in the service. This meant the provider was taking the necessary actions to ensure people were being cared for by staff who had been appropriately recruited.

Staff told us they were aware of the whistle-blowing procedures and who they would go to in the home to raise any concerns they had. We had evidence of staff knowing how to whistle blow prior to our inspection.

We saw the provider had in place cleaning schedules. We walked around the home with the manager and checked with them on the cleanliness and infection control arrangements. We looked at the audits on mattress cleanliness and found there were gaps in the monthly audits. We also looked at the recommendations made by the Prevention and Infection Control Team in September 2014; their recommendations included a monthly mattress audit check. This meant the provider was not maintaining regular checks on the cleanliness of mattresses.

In one shower room we found a wheelchair with a dirty cushion, notices on the doors were stained and there was no personal protective equipment available to staff in the bathroom. In another shower room we found the underside of the shower chair was stained brown. We saw the sluice was splattered with brown stains. In a bathroom we founded weighing scales to be dirty and brown stains in the bath. We looked at the toilet frames and found some of these to be stained brown on the underside. Underneath one toilet frame we found excrement.

In the seating areas next to the dining room we found the floor to be dusty. Some of the seating in the lounge was stained and required cleaning.

In a bathroom accessed by people with dementia type conditions we found curling tongs, a hoist, a table, a chair and laundry bags. During our inspection we discussed with the manager the use of the bathroom and how people can access the bath. The manager agreed the bathroom needed to be cleared and put to use so people can be offered a bath. The Prevention and Infection Control Team did a further visit following our inspection. They shared their report with us which said, 'Please clear the bathrooms of all extraneous items'. We could not be assured the manager had followed up the action to clear the bathroom and make it safe for people to use.

We looked at people's rooms and found one room to be smelling of urine. We asked the manager about the room and she told us the person was incontinent. The manager agreed to arrange a deep clean. We looked at the bumpers on the bedrails in one person's bedroom. The person was being nursed in bed and we found the bumpers were dirty with brown stains.

We found there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In one whistle-blowing call one member of the public told us about a person who had the wrong sensor mat in their bedroom. Following the call we spoke to the nurse on duty to make sure the person was safe and had the right sensor mat in place. The mat was designed to emit a sound if the person got out of bed and to prompt staff attention to make sure the person did not fall. During our inspection and tour of the building with the manager we saw in another person's bedroom a wheelchair sensor mat in place on the floor of a bedroom, the long bedside sensor mat was under the bed and not working. The manager apologised for this issue and immediately called the handyman to ask for it to be replaced. This meant that following our call to the home regarding sensor mats another person was found to have the wrong mat in place.

We saw that accidents and incidents were recorded and these were monitored by the manager to see if improvements could be made to reduce risk to people.

We looked at five people's care records including their care plans, risk assessments and daily notes. We saw that people were assessed prior to living in the home and their needs were documented. We also saw current care plans and there was evidence of monthly evaluation and

Requires Improvement

Is the service safe?

multidisciplinary reviews. However not all plans and entries were signed and dated correctly. We found mobility assessments had been completed and support plans were in place and falls risk assessments were in evidence.

We looked at records of daily checks and found there were gaps in the checks of people. We saw one person was expected to have hourly checks and found on one day there were no checks after 1.30pm, three days later there were no checks recorded between 7am and 7.30pm. We spoke to the manager who said this was down to a nurse who had told the manager they had checked the person but did not have time to write down the checks. We could not be assured these checks were carried out. One whistle-blower told us the manager had taken people off checks. We spoke to the manager about this and she explained some people were being regularly checked who did not need the checks in place as the checks were not about them being safe. She told us some of the checks were about behavioural issues and should be monitored by staff in their normal duties.

We found there was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at people's medicines administration charts (MAR) and found three gaps during the last four week period. The manager had introduced weekly medicines audits to be carried out each Sunday which meant these gaps were identified and addressed. We saw these audits had been completed and staff confirmed they carried them out. The audits identified actions which had been followed up. We checked on the staff who gave out medication to ensure they had been assessed as competent to give people their medicines. The manager was unable to give us one staff member's competency assessment on the first day of our inspection. She assured us this would be carried out immediately. This meant that not all staff had been assessed as competent to give people their medicines. On the second day of our inspection the audit had been carried out. This meant the risk of a staff member giving medication safely to people had been reduced.

We found the provider had in place a 10 point MAR check and checks were recorded as being carried out every day. Staff on duty explained to us about the use of covert medication with one person. They explained about the assessment of the person's capacity, how consent had been obtained, and how they covertly gave the medication to the person. We found the provider had followed the correct care planning for people who were being given their medication covertly.

Personal evacuation plans were in place and we found these were current with a review date identified; however we spoke to one member of staff who did not know when the fire alarm test took place. One relative we spoke with told us they were concerned about the lack of fire safety information visible in the communal areas. They explained on one occasion the fire alarm went off during their visit and they were not sure what to do as staff had not informed anyone of a planned test. They told us several minutes went by before a member of staff informed people and their visitors that it was a false alarm. During this time their relative was becoming increasingly anxious and they were aware that their relative would need a great deal of support to evacuate the building.

We looked at the safety of the premises and found a recent gas safety installation report and an inspection of the fire system had been carried out within the last four months. We saw the provider had in place arrangements for the maintenance of the premises and these were up to date.

One relative commented that they thought the person who lived in the home was safe, but highlighted to us that the code to access the lift in reception is visible to anyone coming into the reception area and potentially unwanted visitors perhaps could gain unauthorised access to the service.

Requires Improvement

Is the service effective?

Our findings

One person told us their relative was, "Clean and well looked after."

We looked at one person's records and found they had displayed behaviour which challenged the service. As a result of this the manager had called in the challenging behaviour team who worked with the service to find ways of better managing the person's presenting behaviours. This meant the service was engaging other professionals to enable them to become more effective in caring for people.

We looked at people's fluid balance charts and found staff were recording people's intake of fluid, however there was no expected level of intake recorded in line with any care plan objectives. When staff were asked to describe a person's fluid intake on the chart as poor, average or good their assessment varied. For example in one person's records they consumed 1350mls on one day and the staff described that as average, on another day they consumed 850 mls which was also described as average, but on a third day they consumed 1200mls which a member of staff described as 'poor'. We found that differing fluid intake amounts did not trigger any action on the daily recording sheet or changes in the overall care plan. We also found not all charts had been completed. We found staff needed further training to be able to make judgements about people's intake of fluid and be able to assess its impact.

We looked at the arrangements in place to support staff. One member of staff told us they had experienced disruption over the last few months due to changes in managers.

We asked to see a list of training given to the staff and the manager gave us a list of care planning and moving and handling practical training. Out of 33 staff listed for a moving and handling practical training session we found 12 staff whose training was out of date. We looked at the e-learning training on dementia which was described as 'mandatory' and found three out of 47 staff had not started their e-learning training. The manager showed us certificates for seven staff who had recently attended specialist training on PEG feeding. We spoke to three members of staff who told us they had not received any training on the Mental Capacity Act.

We looked at staff support through supervision meetings. A supervision meeting takes place between a manager and the person they are supervising to discuss any concerns the supervisee may have, along with their training needs and any conduct issues. We saw the provider had in place supervision meetings. One member of staff told us they had supervision with their line manager every two months, another staff member said they had worked in the service for over six months and had not had supervision. We looked at supervision records and found not everyone had up to date supervisions. This meant supervision and support was not being consistently delivered to all staff. The manager told us there would be greater capacity for supporting staff in the near future when the new senior staff she had appointed started work.

We also examined eight people's records in relation to their wound care and found the provider had in place wound assessment, treatment and management plans. However in one person's file there was no evidence of a treatment plan, in another person's file we saw body maps used to identify where people's wounds were had not been completed. We also found the monthly skin check was not always documented as having taken place. We found the service uses one treatment chart for multiple wounds which can result in confusion over which wounds were still being treated and which ones were resolved. We discussed these arrangements with the manager who felt that wound management information should be in individual people's file and there should be a separate chart and treatment plan for each wound to minimise any possible confusion.

We saw the positional change charts were held in residents' rooms for care staff to use. We saw 'turn' charts required two signatures of staff to confirm the intervention had taken place. It was noticed by the inspection team in some instances the same handwriting appears to have signed for both parties involved in the procedure. We pointed this out to the manager as it could mean staff were signing to say they had completed interventions which were contributed to by other staff. A number of archived positional change charts for October 2014 were examined and found to be complete with no evidence of missed planned turns.

We found there was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS),

Requires Improvement

Is the service effective?

and to report on what we find. We saw policies and procedures were in place and the manager was able to explain the procedure for submitting an application to the local authority. The manager told us about their plans to remove the locks from the dementia unit and allow people with dementia type conditions access to greater space in the reception area. She told us there would be a lock on the front door to keep people safe. We asked the manager about people whose liberty needed to be restricted to keep them safe. The manager showed us she had submitted a DoLS application for a person. We saw people whose liberty was being restricted and we asked the manager about other people for whom she would need to make a DoLS application. The manager looked at the board which listed people's names and the manager considered other people who may require a DoLS application. We found the provider needed to undertake further work and make DoLs applications for people whose liberty it was restricting.

We saw people with bedrails in place and found the provider had undertaken an assessment of their needs which included family members. The provider had completed capacity assessments and looked at risks before bedrails had been used with each person. We found the provider had in place continuous monitoring arrangements of bedrails.

We spoke to relatives about nutrition, one relative commented that "There was a better choice of meals now" and "There is fresh fruit available now", and one resident said the food was "Good". We saw the service had in place a menu and people chose what they wanted. We observed people being supported to the dining room and being encouraged by staff to eat their meals. Once at the dining tables people were offered choices and they ate their meals without complaint. We looked at people's weights and found some people were weighed weekly and others were weighed monthly. We found there were minor gains and losses in people's weights but most people's weights remained stable. This meant people's diets were sufficient to maintain their weight.

Good

Is the service caring?

Our findings

The relatives we spoke to were unanimous in their praise that staff were caring and one resident said "It's always nice here. One relative said, "I find the home very caring." Another relative said, "Staff do a fantastic job." One person told us, "The staff are lovely", but they also said they would like something to do as they got "Bored." They told us about the singers who come into the home. One relative remarked although there is a minibus it "Seems rarely used for outings due to staff shortages". The manager told us of their intentions to increase outings and a recent discussion they had experienced with a person's relative seeking permission to take their relative out of the home. Another relative commented that there was "Very little in the way of activities taking place", and said "It would be a good idea to have a selection of talking books for people who cannot read anymore."

We spoke to the activities coordinators who showed us their plans and discussed with us whilst they undertook group activities some people were unable to be in a group and they carried out individual activities, for example one person liked to go to the shop. They felt the work they did with individual people was not visible to relatives coming into the home. We saw the plans in place involved people in the things they liked to do. The manager and the activity coordinators told us about a recent trip to the Metro Centre where people had enjoyed seeing the Christmas decorations and had wanted to spend so much time there they got back much later than planned. The manager told us plans were in place to have a Christmas fayre and involve service users.

Staff talked to us about the people they cared for and told us about people's likes and dislikes. They spoke about people warmly and gave us information about their past to indicate they knew about the people they were caring for. When people mentioned names we asked staff about who people were talking about. They were able to tell us the significance of the name to each person, for example one person spent time talking to an imaginary presence in front of her. The staff told us the person was talking to their partner and about the context of the conversation. This meant staff had the knowledge about people, and were able to relate to them when people wanted to talk. One member of staff observed an inspection team member talking to the person from a respectful distance and provided information to the team member to enable them to have conversation with the person.

In our observations we noted staff treated people with dignity and respect. We saw people's room doors were kept closed when people were being supported with their personal care. We observed staff interactions with people and saw the interactions were meaningful to people. For example one person carried with them a soft toy animal and staff related to the person by discussing with them the care of their pet and listening to them about their pet's activities. People who were unable to verbally express their views appeared comfortable with staff who supported them. We saw people smile when staff approached them.

We looked in people's rooms and found these to be personalised with people's own photographs and ornaments. There were pictures on people's doors which related to their personal likes. For example on one person's door there was a picture of a necklace as they like to wear their jewellery. This meant staff were reminded about small items which supported a person's well-being before they entered their room.

Requires Improvement

Is the service responsive?

Our findings

Relatives commented to us that the service is not always responsive to the needs of the residents; one relative said "There's a lot of waiting for staff". Another remarked that they liked the activities co-ordinator saying, "She's a trier". This meant they saw the activities coordinator as someone who repeatedly tried to engage people in activities.

When we spoke to some relatives they told us they would like to see the lounge and dining room areas swap locations with each other so that the lounge would then be closer to where the nursing stations are situated allowing staff to be more accessible to residents and more able to observe and hear any call for help. We observed the lounge area where a number of dependent residents were placed when out of their rooms, there was no way of them alerting staff for attention if for example they wished to go to the bathroom, other than shouting for staff. We saw there was an emergency call button in the lounge but this was only in reach of staff, visitors and the most mobile and mentally aware residents. A relative said that these shouts can go unheard or unanswered for "Quite a while" as the lounge was so far from the nursing station. A relative held the view there was often not enough staff on duty and on occasions it is the visitors that make the afternoon beverages for the residents. But the relative also stated that "You can't fault the staff, they do a difficult job". And despite these shortcomings they had "A lot of confidence in the place".

We saw the service is responsive to peoples' needs by holding clinical reviews involving family members and other professionals. However one person's family member told us they had been waiting for a physiotherapy assessment to take place since August 2014, and have not had any feedback from Rushyfield staff relating to the referral progress. Also although the relative stated that they had a "Good relationship with staff" and they "Try their best", they thought that the recent changes to their relatives' medication was making them "Too drowsy" and if they were asked if their relative had improved following the recent review, they would have to say, "No". We spoke to one relative following a clinical review and they were happy that all areas of their relative's care had been addressed.

We saw the provider had in place a complaints policy and the complaints were documented in line with the policy. We saw the provider had responded to the complainant within three working days to acknowledge their complaint and responses had been provided in writing. We found people could be confident if they made a complaint that it would be responded to.

We saw one person had a serious accident in the home resulting in a hospital admission. On discharge from hospital they returned to live at Rushyfield Care Centre in a different unit. The person's updated care plan stated they needed full support for personal hygiene and support for eating and drinking. There were no further details as to how the support should be given. We found their personal evacuation plan was dated prior to their accident and stated '[Person] is mobile but needs staff to guide [them] to a place of safety'. We found their personal evacuation plan had not been updated. This meant that whilst the service had accommodated a person whose needs had changed the documentation failed to detail those changes.

We looked at people's behaviour charts and found staff were not recording outcomes and interventions to enable staff to learn about what works when responding to a person. We discussed our concerns with the manager who told us the recording form was in the process of being reviewed.

We found there was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager had been in post for eight weeks. She told us of her intention to apply to become the registered manager of Rushyfield Care Centre.

We discussed with the manager the changes which they felt needed to take place to improve the home. They told us about changes to the structure of the building so people with dementia type conditions had access to a larger area including the reception area. During our inspection we saw the work being carried out.

One relative told us, "The manager has implemented some positive changes." Another relative we spoke to commented that they liked the new manager and was of the opinion that the service was beginning to improve under her leadership, stating "She's got a grip".

We looked at the minutes of two recent staff meetings and found it was recorded that the manager had responded to the staff raising issues and gave direction to staff. In one of the whistle blowing calls one person said the manager had said, "If you don't do eLearning don't come back." The manager denied she had said this. We saw in the minutes of the staff meeting dated 14 October 2014 the dialogue between the manager and staff was recorded. The minutes stated the manager had said 'E-learning, our training is the worst in the north east could you please check your training to ensure it is up to date, please also look at doing some optional training. Some people have not done any yet – please be aware if you don't start doing this I can and will stop you from coming in and doing any shifts'. We found the staff had interpreted the threat by the manager to stop their shifts as an indication not to come back. We found this was not a positive management approach to use.

In the same minutes of the staff meeting we saw recorded, 'Appraisals – thank you to those of you who have done your appraisals, I've only managed to do one but will do the rest as soon as I can. If you have not got one please get one ASAP'. We found the comments recorded placed an emphasis on staff to get an appraisal rather than on the management to lead the appraisal process.

We saw the regional manager undertook a monthly visit to audit the service and completed a report. The report listed actions for the manager to complete with dates for completion. This meant the provider was assessing and monitoring improvements to the service. Some of the completion dates were prior to our inspection visit and we saw there were no actions recorded as being completed. We discussed the actions identified during the audit dated 23 October 2014 with the manager who explained that they had not been able to carry out the actions as they had not had a deputy in place. They told us a new deputy manager had been appointed and was due to start soon and this would increase the management capacity to carry out these actions.

The manager showed us an annual audit timetable which included medication audits, care planning audits, pressure care audits and infection control audits. As the manager had been in post for a short period of time we found not all audits had been completed. We saw recent audits including kitchen, laundry, maintenance and food and mealtime audits had been carried out in September 2014. We also saw the manager completed a provider monthly report which included untoward events, hospital admissions and accidents.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **We found the provider did not at times have sufficient staff on duty to ensure people were safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **We found the provider had not maintained appropriate standards of cleanliness and hygiene.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **We found the provider had not maintained accurate records in respect of each service user.**