Ms Mary B Rushe

Rushes House Care Home

Inspection report

2 St. Martins Road
Marple
Cheshire
SK6 7BY

Tel: 01614277332

Date of inspection visit:
27 September 2022
28 September 2022
29 September 2022

Date of publication:
04 November 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rushes House is a residential care home providing accommodation and personal care to up to 17 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 15 people using the service. The home is an older building providing single and double occupancy rooms and some rooms have en-suite facilities.

People's experience of using this service and what we found
Prior to this inspection a newly employed staff team had raised concerns with the local authority about the care and treatment of people living at the home. This information had led to an investigation by the local authority who took immediate steps to safeguard people living at the home and prevent the current registered individual accessing the home, whilst their investigations were ongoing. The local authority also shared information with The Care Quality Commission. During this inspection we found that the new staff team were providing people with kind and compassionate care and had begun to make improvements to care and support delivery. The local authority had provided a package of on and off-site support to the new team. The following statements are related to the care and treatment people were experiencing prior to the arrival of the new staff team and ongoing issues that were still in the process of being addressed.

People had not always been protected from the risk of abuse. We received allegations that people had been subject to institutional abuse by the registered individual. This included visiting and other restrictions, lack of choice, inappropriate use of control and verbal abuse. The local authority safeguarding teams were carrying out several investigations relating to abuse and poor care.

People were at risk from unsafe medicine management and administration. Staff had not had up to date training or competency checks and people did not always receive their medicines as prescribed. People had not had their risks appropriately assessed and safely managed. We found concerns with infection prevention and control, and some people's bedrooms were unclean and malodourous. We identified concerns with the safety of the environment.

People had not always been supported to eat enough food and have a balanced diet. Appropriate advice had not been sought from the dietician regarding the management of some people who were at risk of malnutrition. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People had not always been treated in a kind, caring and compassionate way and relationships with family were not always respected. People's autonomy and independence to make their own choices and decisions about their care was restricted.

There was a lack of working together with external agencies to deliver effective care and treatment and support people's access to healthcare services. This meant their needs were not being met and had a negative impact on people's well-being. People had not received personalised care that was responsive to their needs.

The management and leadership of the home by the registered individual was inadequate. There were widespread and significant shortfalls in the quality and safety of the service. Systems to monitor, assess and improve the service being provided were ineffective or not in place. There was a negative culture and people's equality and human rights were not respected.

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

Rating at last inspection
The last rating for this service was good (published 24 July 2019).

Why we inspected
The inspection was prompted due to concerns received from the local authority about allegations of institutional abuse, unsafe management of medicines, unsafe and unclean environment and staffing. A decision was made for us to inspect and examine those risks.

The registered individual agreed to have no contact with people living at the home, relatives and staff. The local authority and a new staff team provided support to people living at the home and a new provider commenced their registration with CQC to ensure people could remain living in their home.

Enforcement
We have identified breaches in relation to safeguarding people from abuse, person-centred care, people being treated with dignity and respect, consent to provide care and treatment, management of people's risks, safe medicine management and administration, safe environment, infection control, poor nutrition and hydration, staff training and support and poor governance of the home.

The registered individual for the service applied to deregister the service at the time of the inspection. An application to register the service with a new provider has been submitted.

Follow up
We will re-inspect the service under the new registration arrangements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Rushes House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors, 1 inspection manager, 1 pharmacist inspector 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.

Service and service type
Rushes House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rushes House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
The care home was owned and managed by the registered individual and was not required to have a registered manager. During the inspection, the registered individual submitted their application to deregister from this service. A staff member from the newly employed care team has applied to be the new registered manager for the service.

Notice of inspection
This inspection was unannounced on day one.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We reviewed recent information of concern shared with us by the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 3 visitors about their experience of the care provided. We spoke with 6 members of staff including care staff, the chef and administrator. We reviewed a range of records. This included 7 people's care documents and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed. After the inspection we reviewed additional information sent through to us by the administrator.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

A new staff team recently started working at Rushes House and raised concerns about the people living there and their experience of care and the culture of the home. The evidence commented on throughout this report is based on what people told us and what we found. At the time of our inspection, the registered individual was no longer present in the home at the request of the local authority, pending safeguarding investigations. The new staff team and their manager were working hard to address the issues found during this inspection and were receiving support and guidance from the local authority. However, our judgments of this service are based on the evidence we found about the care and treatment provided to people by the registered person, prior to the new team's arrival, and the ongoing matters that remain to be addressed.

Systems and processes to safeguard people from the risk of abuse

- People had not been effectively safeguarded from abuse and improper treatment.
- Prior to the inspection, we received information of concern regarding allegations of abuse of people at the home. The local authority were carrying out several safeguarding investigations into wide-ranging allegations of poor treatment, coercive behaviour, restrictive practice and verbal abuse.
- Systems and processes were not in place to protect people and direct staff how to take action. Staff did not have up-to-date training and statutory notifications had not been submitted to CQC as required.

People had not been protected from the risk of harm and abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new staff team had not been implicated in allegations of abuse at the home.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People had been exposed to serious risk of harm due to a lack of person-centred risk assessments or risk management plans.
- Risk assessments were either not completed, not accurate or reflective of people's current needs, or detailed enough to guide staff on how to safely support people. Assessments and care plans were not effectively reviewed regularly or reviewed after an incident had occurred.
- There was no evidence that accidents and incidents were thoroughly investigated, and actions taken to mitigate future risk. Where people had risks to their health and safety, there were no measures in place to reduce the risk. For example, one person had fallen from their bed and sustained a serious injury; however, there had been no review, no investigation and no control measures put in place to reduce the risk of a further fall or to minimise an injury.
- We found some people had a specific risk of harm; however, staff were not directed to manage and reduce the risk. For example, one staff member told us 4 people were at risk of falls but they had no plan in place to

manage and reduce this risk.
● Environmental risks to people had not always been addressed. We found multiple health and safety issues that placed people at the risk of harm. These included; no radiator covers in place to protect people from hot surfaces, window restrictors not always in place, lack of emergency cords and lockable doors in bathrooms and toilets and wardrobes were not always safely secured to the wall.
● Fire safety checks were in place, but we did not see evidence that staff regularly practiced fire drills or had fire safety training.

The registered individual had not ensured that risks to people had been assessed, managed and mitigated. This placed people at the risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager was now reviewing people's care to ensure risks were managed safely.

Staffing and recruitment
● We were unable to ascertain whether staffing levels were sufficient or whether staff had been trained or recruited safely.
● Staff records were in disarray, incomplete or missing. It was unclear how many staff were employed and in what capacity and whether safe recruitment checks had been carried out. We were told all care staff were bank staff and there were no permanent care staff employed. However, we found one staff member on duty who told us they had a permanent contract.
● We saw no evidence staff had completed a programme of training, competency checks, supervision or appraisal. The home administrator demonstrated to us the online training software and this showed no staff had up-to-date training in place.

There were not enough suitably qualified and competent staff in place across the service to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new staff team had been recruited safely and were appropriately trained to care for people. As a result of the safeguarding investigations, the local authority provided some staff from their own services to assist the new care staff to support and care for people.

Using medicines safely
● Medicines were not managed, stored or administered safely.
● We were not assured that people had received their medicines as prescribed. We found missing signatures on people's medicines administration records; therefore, it was not clear if people had received their medicines. We found one person was receiving regular injections, but records were unclear if staff were administering these or the person was self-administering.
● Some medicines were out of stock leading to people not receiving their medicines. Times of administration were not recorded; therefore, we were not assured there was a safe gap between doses. Pain patch rotation charts were not in place.
● We saw no evidence staff had received regular medicines training or competency checks.
● The medicines fridge was unplugged with medicines inside. The medicines room, cabinets and medicines trolley were not secure. We requested these were fitted with appropriate locks during the inspection.

The registered individual had not ensured that medicines were managed or administered safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- There were shortfalls in relation to the management of infection and prevention control.
- There was a strong malodour in some people's bedrooms that could be detected in communal corridors. We requested people were moved out of these rooms due to the malodour; however, there were no alternative rooms available. Some communal carpets were not clean and also required replacement.
- Staff did not always wear appropriate personal protective equipment. We saw staff not wearing masks. Staff told us there was no colour coding of aprons/gloves for different tasks. One kitchen staff member was wearing false eyelashes and nail paint.
- Used medicines pots were being dried on an unclean radiator in the kitchen. Baskets for used laundry were stored in corridors and communal bathrooms.

People had not been adequately protected against the risk of poor prevention and control of infections. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new domestic staff team were working hard to clean the home and cleaned the malodourous carpets daily.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

A new staff team recently started working at Rushes House and raised concerns about the people living there and their experience of care and the culture of the home. The evidence commented on throughout this report is based on what people told us and what we found. At the time of our inspection, the registered individual was no longer present in the home at the request of the local authority, pending safeguarding investigations. The new staff team and their manager were working hard to address the issues found during this inspection and were receiving support and guidance from the local authority. However, our judgments of this service are based on the evidence we found about the care and treatment provided to people by the registered person, prior to the new team's arrival, and the ongoing matters that remain to be addressed.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The service had not always worked within the principles of the MCA.
- Consent to care and treatment had not always been gained from people. Where people had the capacity to consent, we found consent had not always been recorded. Where there were concerns over a person's ability to consent, legal processes were not followed to ensure decisions were made in their best interest.
- We found evidence the registered individual had signed Covid-19 testing consent forms to state people had capacity to consent. We found these people did not have capacity to consent.

● Covert medicines were not being given in accordance with the Mental Capacity Act 2005. Covert medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. For example, for one person, staff did not have clear guidance on what medicines were to be administered covertly. There was also no advice from a pharmacist about how the covert medicines could be given safely. We saw no evidence of an appropriate best interest decision made to give medicines covertly.

Care and support was not provided within the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People had not always had their nutritional and hydration needs met.
● People had not had their weights or BMI checked when needed and people did not have nutritional or hydration risk management plans. The new staff team carried out weight and BMI checks during our inspection, which identified people required referrals to medical professionals and these were then arranged.
● We found two people did not have the capacity to make decisions about their nutritional needs and the diet they were being offered was neither varied nor nutritious.
● There were no referrals made to medical professionals, including dietician, speech and language therapy (SALT) or their GP where people had nutritional needs due to their conditions.
● People had not always had ready access to drinks. There was a water cooler in the foyer; however, one person told us they had not been allowed to use this as it was for staff use only. The water cooler was unplugged throughout our inspection. Drinks were served at set times only.
● People were not able to make choices about what they ate and people had not been consulted on menus. The menus were decided by the registered individual, there were no menus available for people to know what was being served each day and there was only one hot meal served at lunchtime. Breakfast was cereal and toast. Snacks, such as soup and sausage rolls, were left by the chef for teatime.

The registered individual had not ensured that people's nutritional and hydration needs were met. This placed people at the risk of harm. This was a breach of regulation 14 (Nutrition and Hydration) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new staff team had ensured everyone at the home was being offered nutritious meals and had introduced a hot breakfast choice and suppers.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Appropriate and detailed assessments of people's needs had not been carried out.
● Care and support did not reflect current evidence-based guidance, standards and practice. People who were at risk of certain conditions, such as, skin breakdown, did not have appropriate assessments in place.
● No outcomes were recorded for people and care documentation did not accurately reflect their current needs. This meant people were at risk of not having their needs safely and effectively met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had not always had access to timely medical care and had not always had referrals made to appropriate healthcare services.
● We found no evidence that people who had been living at Rushes House had been referred to healthcare professionals when required such as, podiatry, physiotherapy, the falls team and optician.

● One person was the subject of a safeguarding investigation where they had fallen from their bed and suffered injuries; however, they had not received medical attention for several days. We also saw one person had suffered several falls; however, we saw no evidence this person had received a referral to have investigations into the cause of frequent falls.

Staff support: induction, training, skills and experience
● Rushes House staff were not adequately trained and did not receive regular supervision, appraisal or competency checks.
● Staff working under the registered individual had not recognised and reported poor practice at the home.
● Staffing is further reported on in the safe section of this report.

Adapting service, design, decoration to meet people's needs
● We saw no evidence that people had been involved in the design of the premises.
● Some areas of the home were tired and required refurbishment. There was no dining room at the home and people had their meals in the two small lounge areas with individual tables over their knees.
● The home had WIFI and this had allowed one person to have video calls with overseas relatives. However, staff and one relative told us they were unable to access the WIFI as the registered individual had changed the password so it could not been used by people and staff.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

A new staff team recently started working at Rushes House and raised concerns about the people living there and their experience of care and the culture of the home. The evidence commented on throughout this report is based on what people told us and what we found. At the time of our inspection, the registered individual was no longer present in the home at the request of the local authority, pending safeguarding investigations. The new staff team and their manager were working hard to address the issues found during this inspection and were receiving support and guidance from the local authority. However, our judgments of this service are based on the evidence we found about the care and treatment provided to people by the registered person, prior to the new team's arrival, and the ongoing matters that remain to be addressed.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People had not always been treated or spoken to with dignity and respect.
- Some people told us they were under the control of the registered individual and they were fearful of consequences for them.
- People had not been cared for by permanent staff who knew them well as most staff were bank or agency staff. Information in people's care plans did not direct staff to people's history, preferences and immediate care needs.
- Some people's toenails were overgrown and there were no visitors to the home to provide additional personal services, such as, a hairdresser.
- The registered individual had visiting restrictions in place. Visitors told us they had always had to telephone the registered individual and make an appointment in advance to visit their loved one and visiting could only take place in the person's bedroom. They told us visiting was only allowed within these conditions.
- People were left in undignified situations. People were eating meals and sleeping in rooms that were unclean and very malodourous.
- People were not always supported to be involved in decisions about their care. Care records showed a lack of assessment and involvement from people and their loved ones.
- Relatives told us communication with the home was poor and they found it difficult to find out how their loved one was.
- We did not see evidence in care records that people's specific communication needs had been assessed to enable them to effectively express their views.

● People had not been supported to maintain their involvement in the community and maintain their religious needs. One person told us, "Years ago [Name] stopped me and [Resident Name] going to the local Methodist Church which is the nearest. We used to get a taxi but [Name] stopped us going."

People were not treated with dignity and respect at all times and were not supported to express their views. This placed people at the risk of harm. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new staff team treated everyone in a kind and compassionate manner and respected people's privacy and independence respected. They had also arranged for everyone to have their hair done at the home. Visiting restrictions had been lifted and relatives could now visit freely.

Ensuring people are well treated and supported; respecting equality and diversity
● Feedback from people and relatives about the treatment of people at Rushes House was consistently poor.
● People's personal possessions such as clothes and personal items were not always treated with respect. One relative told us they had recently bought their family member new clothes and they had all gone missing. They said, "[Name's] glasses went missing, her teeth went missing." They told us they spoke with the registered individual who commented, "Well, [Name] doesn't need their teeth."
● We saw no evidence that people's individual and specific needs had been assessed and acted upon. For example, people who found eating food difficult had not been assessed for any kind of adapted cutlery or plate guards.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

A new staff team recently started working at Rushes House and raised concerns about the people living there and their experience of care and the culture of the home. The evidence commented on throughout this report is based on what people told us and what we found. At the time of our inspection, the registered individual was no longer present in the home at the request of the local authority, pending safeguarding investigations. The new staff team and their manager were working hard to address the issues found during this inspection and were receiving support and guidance from the local authority. However, our judgments of this service are based on the evidence we found about the care and treatment provided to people by the registered person, prior to the new team's arrival, and the ongoing matters that remain to be addressed.

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

- People and their loved ones had not been involved in assessments or reviews of their care and support needs and treatment. Care plans and assessments had been written by the registered individual with no evidence of input of the person, family or other professionals.
- Care plans were not reflective of people's needs and individual preferences to guide staff to provide person-centred care how the person likes their care delivered. Information was out of date, inaccurate or missing. One new staff member told us they like to have information, so they have something to talk about with people, but there was nothing in care plans. They told us, "There is nothing. For example, allergies and what they like and dislike. Nothing in them; I don't know anything about anyone."
- People's preferences were not met and told us they lived under the control of the registered individual. One relative told us, "[Name] had a bird feeder at [Home name] and the residents used to like the birds and squirrels. [Name] said [Relative] couldn't bring it to Rushes House." One person told us, "The atmosphere is better now [Name] has gone and more relaxed and I can say what I want and ask for a cup of tea. Life here was the worst mess I've ever been in." One relative told us the registered individual had insisted their loved one take their medicines and go to bed at 8pm when this is not the person's preference and caused them anxiety.

The registered individual had not ensured people received person-centred care that met their needs. This was a breach of Regulation 9 (Person-centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People had not been supported to participate in any activity that was meaningful to them and promoted

their wellbeing.
● There was no provision at the home to provide any activities or entertainment. People and staff told us there was no activities and no activities co-ordinator in post. One relative told us, "When [Name] first came we asked about entertainment and they said they had it but there is nothing at all. A couple of times people have been on a narrow boat, but [Name] didn't go on any. They [Relative] has not left this home for years."
● People's cultural and spiritual needs were not considered or recorded in people's care records.

The registered individual had not ensured people were supported to follow interests and receive meaningful individualised care. This was a breach of Regulation 9 (Person-centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's individual communication needs had not been assessed and no information was detailed in care records.
● We saw no evidence of any information given to people living at the home.

Improving care quality in response to complaints or concerns
● Information about how to make a complaint was not accessible to people and their relatives.
● There was no information displayed in communal areas. There was a comments book in reception. However, this was in a closed drawer and there were no entries made.
● Please see the well-led section of this report.

End of life care and support
● Staff had not received training in how to care for someone at the end of their life.
● We saw no evidence that people had been involved in making their wishes known for their end of life care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

A new staff team recently started working at Rushes House and raised concerns about the people living there and their experience of care and the culture of the home. The evidence commented on throughout this report is based on what people told us and what we found. At the time of our inspection, the registered individual was no longer present in the home at the request of the local authority, pending safeguarding investigations. The new staff team and their manager were working hard to address the issues found during this inspection and were receiving support and guidance from the local authority. However, our judgments of this service are based on the evidence we found about the care and treatment provided to people by the registered person, prior to the new team's arrival, and the ongoing matters that remain to be addressed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We found widespread concerns regarding the conduct of the registered individual and the overall management of the home.
- The registered individual did not demonstrate effective oversight to ensure people received high quality care in a safe environment. We found breaches of regulation in areas such as person-centred care, dignity and respect, consent, environmental risk management, risks to people's health, medicines management, infection control, safeguarding, staffing and people's nutrition.
- People were at risk of receiving poor care because risks to their safety and well-being were not assessed and managed appropriately to protect them from harm. Audits were minimal and were tick box exercises covering mainly the building and environment. There were no audits in relation to the quality and effectiveness of the care provision.
- Statutory notifications to inform us of incidents had not always been submitted as required.

Continuous learning and improving care; how the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was no evidence that there had been any learning from incidents.
- We were not assured that all accidents and incidents had been recorded. There was no evidence of any investigations, follow ups, reviews of any risks or any action taken as a result of accidents and incidents.
- We found no evidence that families had been informed of incidents at the home.
- Opportunities to drive improvement had not been actioned. There was no accessible system in place for people to make a complaint.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; working in partnership with others; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People, relatives and staff told us there had been a negative culture at the home and people had been subject to institutional abuse by the registered individual.

● The service did not work effectively in partnership with others. We saw little evidence that appropriate referrals had been made to other healthcare professionals. The registered individual did not facilitate outside services into the home to provide holistic care.

● Records relating to the care and treatment of each person using the service were not fit for purpose. The registered individual kept paper care documentation and their handwriting was frequently illegible. People or their loved ones were not involved in care planning and reviews.

● There were no team meetings held. Rushes House staff scheduled to be on duty during the week of our inspection reported in on sick leave. We received mixed feedback about Rushes House staff. One person told us, "[New] staff are lovely, but our [Rushes House] staff are okay too but they have to abide by [Name's] rules."

● There were no effective systems for people either individually or in groups to gain their input in how the service was being delivered or how it could be improved. We saw a small number of feedback survey forms had been completed in the last 12 months. However, we did not see any evidence that this information had been analysed and used to drive improvements to the service. One person told us, "I have had a questionnaire, but I have to tell lies in it because I don't want to get in trouble with [Name]. She says what's what."

The registered individual had failed to; assess and monitor the service for quality and safety, maintain accurate records for people and staff, seek and act on feedback and mitigate any risks to people. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received excellent feedback about the new staff team and manager. The new manager has applied to register with the CQC.