Bush Home Limited

Bush Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 23, 24 and 29 November 2017 and was unannounced. At our last inspection in September 2016, we rated the provider as 'requires improvement' in all the five areas we inspected. At this inspection, we found the required improvements had not been made. The service provided to people had deteriorated and the provider was now not meeting all the requirements of the law. Bush Rest Home provides accommodation for up to 44 people who require personal care. At the time of our inspection there were 39 people living there in one adapted building.

During this inspection we identified seven breaches of the Health and Social Care Act 2008 relating to safe care and treatment, staffing, person centred care, complaints, good governance, and failure to display. You can see what action we told the provider to take at the back of the full version of the report.

Bush Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There was a registered manager at the time of our inspection. 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.

Although people told us they felt safe, they were not always protected from the risk of harm because they did not always get their medicines as prescribed. We saw risks to people's health and safety were not always managed in a safe way because staff used unsafe techniques to move people. When people were at risk of weight loss, guidance in place for staff had not been followed and some people had sustained further weight loss. When people sustained falls no investigations had taken place or learning from the accidents to ensure people's risk of falling was minimised. The recruitment system operated by the provider needed to be improved to ensure staff were suitable to work with the people who lived at Bush Rest Home. Staff knew how to protect people from the risk of potential abuse. People told us and we saw there were sufficient staff to keep people safe. People were protected by the potential risks of infection as the home was clean and tidy.

Staff had received some training but it was ineffective as staff were not providing people with safe or

effective care and systems were not in place to ensure staff were competent in their role. Peoples current needs were not always reflected in their care records. People had mixed views about the food. People's nutritional needs were not always being met. People did not always receive co-ordinated care from health professionals. The design of the building was not always suitable for people living with a dementia. The principles of The Mental Capacity Act were not embedded in the care people received as people who had capacity to make their own decisions were not always involved in the decisions about their care. Staff were unaware of the people who had restrictions on their freedom at Bush Rest Home.

People told us and we saw staff were kind and caring but the systems the provider had in place did not always ensure people received compassionate and safe care. People were not always involved with their care. We saw people did not always have choices about their care. Staff did not always respect people's privacy and dignity.

The care people received was not always responsive to their own individual needs. People told us they were bored because they did not have access to activities and no choices in how they would like to spend their time. People told us they had not needed to complain but if they did they would not know how to. The complaints system operated by the provider was not accessible to people who used the service or their relatives. There was a system in place should people reach the end of their lives to ensure they were pain free.

People were not supported by a management team who ensured the care they were receiving was safe. The service did not have systems in place to ensure the care people received was safe, effective, compassionate, and responsive to their own individual needs which meant people had received unsafe care. People had mixed views about whether the service was well led. Staff told us the management team supported them. Improvements were required in the leadership of the service to ensure staff were motivated and had a clear vision as to where the service is heading.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

People did not get their medicines as prescribed or when needed. Risks to people's health and safety were not safely managed. People were not protected from harm as unsafe techniques were used to move people. Improvements were required in the recruitment system operated by the provider. There were sufficient staff to keep people safe. People were protected from the risk of potential abuse because staff knew how to recognise the signs of potential abuse. People were protected from the risks of infection.

Is the service effective?

Inadequate

There was no system in place to ensure staff were competent at their roles which resulted in people receiving unsafe care. The system in place did not always ensure people's nutritional needs were being met. Improvements were required in ensuring the care people received from other healthcare professionals was meeting their needs. People who had capacity to make decisions about their care were not always involved in making choices about their care. Staff were unaware of the restrictions some people had with regards to the care they received.

Is the service caring?

Requires Improvement

The service was not always caring.

Although people told us, and we saw individual staff were kind and caring the systems operated by the provider did not always ensure people got compassionate care. People told us they were not always involved in their care. Staff did not always respect people's privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have care which was responsive to their individual needs. People did not have access to activities of their

choice. People told us they would not know how to make a complaint. The complaints system operated by the provider was not easily available for people who used the service and their relatives to access.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance systems were ineffective which meant people were at risk of harm and some had received unsafe care. The registered manager had not taken action to monitor and improve the quality and safety of the service. Although people and staff were involved in the running of the service this had not led to improvements for people living there.

Bush Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 23, 24 and 29 November 2017 and was unannounced. The inspection team consisted of two inspectors, one of which was a pharmacy inspector who looked at the systems in place to ensure people got their medicines as prescribed. An expert by experience also accompanied us by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

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

As part of the inspection we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We asked for feedback from the Commissioners of people's care to find out their views on the quality of the service. We also contact the local authority safeguarding team for information they held about the service. We used this information to help us plan our inspection.

During the inspection we spoke with nine people who used the service and six relatives. We spoke with the registered manager and seven members of staff and a visiting health professional. We carried out observations throughout the day to help us understand the experiences of the people who lived there. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for seven people and medicine records for 12 people. We looked at other records relating to the management of the home.

These included staff files, accident reports, complaint logs and audits carried out by the registered manager.

Inadequate

Our findings

At our inspection in 2016 we rated the provider as "requires improvement" in this key question. This was because the system operated by the provider did not ensure staff had the information available to them when people received their medicines "as required". At this inspection, we found the required improvements had not been made and in some areas the care people received had deteriorated which meant they were no longer meeting the requirements of the law.

People did not get their medicines on time or as prescribed. We looked at how medicines were managed, which included checking the medicine administration record (MAR) charts and associated records for 12 people, speaking to senior care staff and reviewing how medicines were stored. Although people told us they got their medicines, one person said, "I get my medicine on time", we found recording issues meant that the administration records were not always able to demonstrate people had received their medicines as prescribed. For example, we found that staff initials were missing from the administration record, so we were unable to establish if the medicines had been administered. The receipt of medicines was not always being recorded, the provider was not always taking into account the transfer of medicines from one medication cycle to the next and where medicines had been refused, the disposal of these medicines was not being recorded. The registered manager had failed to ensure staff had the knowledge and skills to administer and record people's medicines correctly.

Our audit showed some discrepancies between the quantity of medicines found and the administration records, which indicated that these people had not received their medicines correctly. For example, the records for a medicine used to treat gout showed that 28 tablets had been received and 32 had been administered from this supply. We had further concerns when we found seven tablets still remained. We also found some people who had been prescribed inhaled medicines were not receiving the dose that had been prescribed. For example, the records showed that one inhaler containing 60 doses had been opened at the start of a medicines cycle and the records showed that during this cycle 56 doses were administered. We therefore expected to find four doses remaining in the inhaler however, we found 54. This meant that people could not be assured that they would receive their prescribed medicines safely. People were at risk of their health deteriorating through omissions in the administration of their medicines.

We looked at one MAR chart to ensure people's nutritional needs were being met. Records demonstrated their nutritional supplements had not been administered in accordance with their prescription. We saw gaps where staff should have signed to say they had administered their nutritional supplement. We asked staff and the registered manager about this. Staff told us they were out of stock of people's nutritional

supplements since the previous week. Staff could not explain gaps prior to this when the supplement was available. We spoke to the registered manager about these concerns who was not aware of the lack of available nutritional supplements and took action immediately to ensure people who were prescribed nutritional supplements had them. However, appropriate systems were not in place to ensure that people's supplements were held in stock by the home and available to be administered to people.

We found the medicine refrigerator temperatures were not being measured correctly to ensure the medicines stored would be effective. For example, readings taken on the day of the inspection showed the refrigerator temperature had dropped below the acceptable minimum temperature. We found that the refrigerator was storing temperature sensitive medicine called insulin and because of it being exposed to the low temperature the provider was advised to obtain new supplies of the insulin and discard the current stock. The insulin held in stock was at risk of not working effectively should it be administered to people because it had not been stored appropriately by the provider.

We looked at the information available to the staff for the administration of 'when required' medicines. We found the protocols were not detailed and did not explain what the terms such as "agitated or aggressive" meant and looked like for the individuals concerned. We also found one person had been prescribed a sedative on a when required basis but this medicine was being administered on a regular basis with no written evidence that the person required it and staff could not explain why it was being administered in this way. This meant people could not be assured that their when required medicines would be managed appropriately by staff. The system operated by the provider did not ensure people got their medicines as prescribed by their doctor.

Although people told us they felt safe, we found when people had been assessed as having risks associated with weight loss, appropriate action had not been taken to manage them. Staff understood how to manage the risks and guidance was available for them to follow, however we found staff had not followed the guidance and therefore the risks to people's health were not being managed safely. For example, we saw in one person's record they needed to be weighed on a weekly basis. Their weight charts confirmed this had not been completed as we found gaps where their weight should have been recorded. When they were weighed, it was found they had sustained 6.7kg weight loss and no action had been taken to address this. We could see no evidence of a dietician's visit since July 2017 and staff could not recall if a health professional had visited. Although the registered manager told us the dietician had visited in August 2017, we could see no evidence of this intervention. The same concerns arose in two further care plans we looked at. We saw these people had also sustained a small amount of weight loss over this period. The registered manager explained that the scales were broken for a period of time, but no further action had been taken to weigh people to ensure they were safe. The registered manager was not able to explain why action had not been taken to replace or repair the scales. The registered manager called the doctor and the dietician during our inspection and asked for an urgent visit to ensure people were safe. The registered manager had not ensured when people were at risk of weight loss correct action had been taken to manage their risks in a safe way. This meant that people were exposed to the risk of harm because the provider had failed to take sufficient action to manage their known risks.

We found risks to people's health and safety were not always managed in a safe way. Staff and the registered manager told us how they managed people's risks; however, we saw they did not consistently provide care to people in the way they explained to us. During this inspection we saw three examples of members of staff moving people in a way that caused an increased risk of injury. For example, we saw one person who was unsteady on their feet being supported by one member of staff. They supported them by offering their hands for the person to use to push themselves up to a standing position. This caused an increased risk to both the person and the member of staff. We looked at this person's records which showed

two members of staff should support the person to mobilise at all times. This meant the member of staff had not supported the person to remain safe in line with their care plan as well as using an unsafe technique to support them to mobilise.

We saw in another person's record a referral had been made to the speech and language therapy team in August 2017, to ask for advice on how to manage this person's risk of choking. While we saw staff had documented the referral had been made, there was no reference to the risk to the person's health, or how staff should manage this risk. Staff told us the person was experiencing difficulty eating food such as toast. Although staff had identified the risk to this person, they had not taken appropriate action in assessing, recording or monitoring the person's risk to ensure steps were taken to reduce it. We saw another person had bed rails fitted. There was no risk assessment to show that this was the least restrictive method of keeping this person safe in bed. Bed rails should only be used as a last option as they can cause an increased risk of entrapment for people. The provider was not taking appropriate action to protect people from the risk of harm.

We found when people were at risk of falling, no action had been taken to reduce the risks associated with this. The management system in place ensured when people fell staff recorded this on accident forms and the information was then transferred into people's care records. We saw the registered manager then recorded on a monthly basis how many falls had occurred and if anyone had had repeated falls. When people fell, we saw no investigations had been carried out. We found one person had fallen when staff should have been present to prevent this. The registered manager's system had not highlighted this as a concern. We found when people had repeated falls, although this was recorded in their care records, no further action had been taken to ensure they were safe. For example, we saw one person had fallen four times in October 2017, and although this was recorded in their care records the information had not been analysed, their risk assessment had not been updated in line with these falls and no action had been taken to prevent further falls. The provider had not ensured when things went wrong action was taken to prevent further risk of harm to their safety. The provider had not ensured risks to people's health and safety were assessed and managed safely which meant people were at an increased risk of harm.

Regulation 12 states care and treatment must be provided in a safe way for service users. The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We found people were not always protected from risk of harm because the recruitment system operated by the provider did not always ensure new staff were recruited safely. Staff told us they had an interview, were asked to bring in certain documents, and then had to wait for Disclosure and Barring (DBS) checks to be completed before they started working alone. DBS helps employers to make safer recruitment decisions and prevents unsuitable people being recruited. We looked at four staff files and found although DBS checks had been completed before staff started working in the service we found in two cases, the registered manager had not ensured they had followed the provider's own recruitment policy. The registered manager told us references had to be taken from previous employers when new staff started. We found in two of the staff files we looked at referees had been given as previous employers who were care providers. The registered manager had not gained references from the named referees, but had obtained references from family members and colleagues instead. Improvements were required in the recruitment system operated by the provider to ensure they were following their own policies and procedures with regards to the recruitment of staff.

We looked at equipment and fire procedures in the home to ensure people were safe when using equipment. We found equipment was serviced regularly and new slings had been bought when the service engineer had failed the old ones. Staff were aware of the fire procedures in the home and we found regular fire checks and water safety checks were carried out to ensure people were protected from harm. We saw regular checks documented on electrical equipment used in the home to ensure it was safe for people and staff to use.

People in Bush Rest Home told us they felt safe. One person commented, "I have no worries, [about my safety]". Staff told us they were aware of the signs of suspected abuse and knew how to protect people. One member of staff told us, "The way people act [differently], may be a sign of abuse." Staff told us they had received training about how to protect people and knew where to go to find the information should they need to make a referral. The registered manager had made referrals to the local safeguarding authority when they suspected any forms of abuse may have taken place. People were protected from the potential risk of harm because staff knew how to recognise the signs of abuse and what to do should they suspect abuse had taken place.

People told us there were sufficient staff to keep them safe. One person said, "There is enough staff around". A relative told us they felt reassured by the fact there were sufficient staff around all the time to protect their family member. Staff told us they thought there were sufficient numbers of staff to ensure people got the support they required. The registered manager told us they regularly assessed staffing levels using a dependency tool, which meant they looked at how dependent people were on staff to provide the care they needed to keep them safe. We saw there were sufficient staff to meet people's needs in a timely way. For example, when people used the buzzers in their rooms to alert staff they required support these were answered promptly. Sufficient numbers of staff were available to meet people's assessed needs.

People told us they found their home clean. One person said, "They always keep the place clean and tidy." We found people were protected by the prevention and control of infection because the provider had a system in place that ensured the risks associated with infection were managed. The registered manager told us this had been an area in which improvements had been made over the previous 12 months. A member of staff had been elected by the registered manager as the lead for infection control in the home and as part of their role they attended regular meetings with professionals to keep up with current practice. We saw audits were carried out by the infection control lead and where areas had been highlighted as requiring improvement these improvements had been implemented. For example, a broken toilet seat had been replaced as well as a broken soap dispenser. We saw staff wore protective clothing when handling food. We saw the environment was clean, tidy, and free from trip hazards.

Inadequate

Our findings

At our inspection in 2016 we rated the provider as "requires improvement" in this key question. This was because people were not always given enough to drink and people could not be assured their human rights were upheld as staff did not always provide care in line with the Mental Capacity Act. At this inspection we found the required improvements had not been made and people's care in other areas had now deteriorated and they were no longer meeting the requirements of the law in some areas.

Although staff told us they had received an induction when they commenced their role and they had received training to support them in their role but there were no systems in place to check their competency when caring for the people in Bush Rest Home. We saw staff did not always have the knowledge and skills to support people in a safe way. We saw staff used unsafe techniques to move people, we saw staff had made errors in the recording of people's medicines; we saw staff had not always considered people's dignity when providing care. The failure of staff to follow the training they had received exposed people to the risk of harm. We found staff did not recognise poor practice when people were in receipt of unsafe care. We spoke to the registered manager who told us staff received training to keep them up to date. Some of the training was only delivered every three years and we saw there were no competency checks and no updated training in between to ensure staff were competent in their role. There were no observations of staff practice when they provided care to people. Records demonstrated staff had not received any specialist training when people had health conditions such as Parkinson's disease. The registered manager told us this was planned for 2018. We found people were not always supported by staff who had the skills and knowledge to support them with their care needs and there was no system in place to ensure staff were competent in their role which had resulted in some people receiving unsafe care.

Regulation 18 states suitably qualified competent skilled and experienced staff should be employed. The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. Staffing.

We received mixed views from people about the food. One person told us, "There is no variety in meals" another person said, "The food is very good". One person told us they did not want sandwiches every night for their tea but no other choice were offered. We observed people having their lunch and found people were given choices about where they would like to eat their lunch. We found when people had a dietician involved in their care due to their risk of losing weight staff had not always followed guidance given by the healthcare professional. For example, we saw in one person's record the dietician had recommended staff needed to offer frequent high protein, high calorie meals to improve the person's nutritional intake and

reduce the risk of weight loss. The staff we spoke with were not aware of this guidance and therefore this was not being offered to them. This meant they were at risk of not meeting their nutritional needs and losing weight. We saw when people were on food and fluid charts to monitor their dietary intake these were not being completed in an accurate way. Staff were unaware of the amount of food and fluids people should be given to ensure their dietary needs were being met. We saw people's fluid intake was not measured on a daily basis to ensure they remained safe and healthy. We saw food was recorded but not quantified. For example, one person's food diary recorded they had eaten a cereal biscuit but not how many or how much. The provider had not deployed appropriate systems to ensure that people were supported effectively to eat and drink enough. People at risk of not eating and drinking enough did not receive the care they needed to maintain their safety. At our previous inspection we noted drinks were not always available when people were thirsty. At this inspection we saw staff offered people a choice of drinks throughout the day. We found people's preferred choices were not always respected by staff and when people had specific dietary requirements they were not always followed by staff.

Regulation 14 states the nutritional and hydration needs of service users must be met. The above evidence demonstrates a breach of Regulation 14 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

People told us they were happy with the care they received and happy that staff supported them well. However, we found people's needs were not always assessed effectively to ensure they received care which met all their individual needs. Staff told us how they cared for people but we found this was not always recorded in their care records. We found conflicting information in one person's care records. For example, we found two risk assessments in one person's care record which stated different methods of how the person mobilised. Staff had signed to say they had reviewed it recently but it did not reflect their current needs. We saw assistive technology had been introduced to support some people with the care they required but this was not consistent across all people who may have benefitted from its use. The registered manager told us they would be looking at other options available to support people with their care needs to ensure they were supported in a safe way. We spoke with a district nurse who visited the home on a regular basis who told us they were happy with the support people received at Bush Rest Home. They told us when people had wounds they had healed well and there had been great improvements in this area over the last 12 months. They told us, "Staff listen and act upon the advice given to them which means people got better outcomes". We found the provider and registered manager had failed to ensure people's needs were assessed and reviewed comprehensively to ensure their care was effective in meeting their assessed needs.

Staff at Bush Rest Home told us they worked with other professionals to ensure people got consistent and co-ordinated care. We spoke with one professional who told us they worked well with the staff which meant people received the care and support they needed. We saw one person regularly visited a day centre and staff at the home worked with day centre staff to co-ordinate their care. However, we saw this approach was not applied consistently across all people. We saw in people's records staff had not followed up on healthcare professionals visits. Staff could not recall if or when the healthcare professional had visited and it was not recorded in people's care plans. We spoke with the healthcare professional who confirmed they had visited but told us as nothing had changed they had not documented their visit anywhere. We found improvements were needed to ensure people got consistent and co-ordinated care and support from other organisations who were involved in their care. Where plans of care had been developed by other professionals such a dieticians this guidance was not consistently followed by staff in the home. This meant that people could not be assured they would receive the care they needed.

People told us they were not always involved in decisions about the environment. The design of the large lounge was open plan. We saw there was no signage to direct people around the home or to orientate people who live with dementia around the home. We saw the carpet which covered the main stairs in the building was worn and the edging strips on the steps to define where the steps were was also dark which meant people living with dementia would not always be able to distinguish where the edge of the step was. We spoke to the registered manager who told us the home was due to be refurbished early next year and there were plans to make the home more dementia friendly. Improvements in the environment were required to ensure the building was suitable for people living with dementia to limit the distress they may have.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw people were asked for consent before care was provided. For example, we saw people were asked if they wanted to wear protective clothing whilst eating and we saw staff respected the choices people made. Staff told us they had received training in the MCA and understood what it meant for people. One member of staff told us, "It's about people who can make their own decisions and people who can't". However, we found the registered manager had not always involved people in making choices about their care. For example, we found one person had bed rails fitted. The registered manager had acted upon the decision of the family and had not involved the person to make their own decision despite the registered manager telling us the person had the capacity to make the choice. We found the same person had a "Do Not Resuscitate" (DNR) which had been in place previously when the person was not well and unable to make the decision regarding if they wanted to be resuscitated. The registered manager had not considered involving the person in reviewing the decision now they had recovered and had capacity to make the decision themselves. We discussed this with the registered manager who told us they would review the documents in people's care records to ensure all decisions were made in people's best interests only when they lacked capacity to do so for themselves. We found improvements were required in involving people who had the capacity to make their own decisions about the care they received.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLs). DoLs require providers to submit applications to a 'Supervisory Body' for authority to deprive people of their liberty. 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. At the time of the inspection only one person living at the home was subject to an authorisation to deprive them of their liberty. The registered manager had applied to the supervisory body to deprive other people but no authorisations had been received. Staff were unaware of the authorisations in place. One member of staff said, "They nearly all have DoLs in place." This meant people were at risk of receiving inconsistent care. The registered manager told us they would discuss this at the next team meeting with staff to ensure all staff had up to date information regarding people who were being deprived of their liberty and why.

Requires Improvement

Our findings

At our inspection in 2016 we rated the provider as "requires improvement" in this key question. This was because people were not always supported to be involved with their care. At this inspection we found the required improvements had not been made.

Whilst we saw individual staff were kind and caring the providers systems and processes did not always ensure that people received compassionate care. The registered manager had not considered when people had risks to their health and safety that these were being managed appropriately. We found people were not always involved with their care and decisions were made about their care without them. We found staff did not always respect people's personal choices and there was no system in place to ensure staff were competent in their role in providing safe, effective compassionate and responsive care for people at Bush Rest Home.

People told us they were not always involved in their care. One person said, "'No I'm not really involved in any planning". They added they weren't aware of any ways they could be involved. Another person told us staff knocked on their door early every morning to wake them up. Although they hadn't been involved in this decision, they didn't mind as they were awake anyway. Although we saw staff involved people about some of their everyday decisions such as where they would like to sit and what they would like to wear. We saw some people were not given choices about this in order to make informed decisions. For example, we saw one person did not like the noise in the lounge when an entertainer visited staff asked them if they would like to sit in another area of the lounge. This meant they would still be able to hear the loud music. It was not until we intervened and asked the member of staff if there was another option available to this person where they would not be able to hear the loud music that the person was offered an alternative to meet their needs, which the person accepted. The registered manager had not ensured people had the opportunity to be involved with the planning and delivery of their care. We saw people were not always offered choices about their care and were sometimes not involved in decisions about their everyday care needs.

People's dignity was not always respected by staff. Staff gave us examples of how they ensured people's privacy and dignity was respected. However, we saw some people received care which respected their dignity; this was not consistent across all staff. The registered manager and staff told us when they weighed people they were weighed in a thoroughfare in the corridor of the ground floor of the home. Other people and visitor's had access to the corridor and were able to see when people were being weighed. The registered manager and staff told us they had not considered people's dignity in doing this but this task had

always been carried out in this public area of the home. The registered manager told us they would move the scales to a private area which meant people could be weighed in a more dignified manner which they had by the third day of our inspection.

We saw one person who had been given their lunch on a cushion on their lap. This meant they had difficulty in eating their lunch and had spilt their food all down their clothes. Staff had not respected their dignity in considering how they would best eat their food. We pointed this out to the registered manager who asked a member of staff to take immediate action to rectify the situation for the person. We saw there were occasions when staff respected people's dignity. For example, we saw a member of staff support a person with their clothes in a dignified way that respected their privacy in front of other people. We found people's dignity was not always considered by staff and the registered manager, however when we intervened action was taken to ensure people were treated in a dignified way. It was a concern however, that it took our intervention to ensure that people were treated with dignity and respect.

People and their relatives told us the staff were kind and compassionate. One person said, "If you ask for anything they will help." Another person commented, They are all kind". A relative commented, "Nothing is too much trouble I have seen how they care for others here". We saw staff spoke to people using terms of endearment and names which people preferred. One person told us, "You can have a laugh with people." We saw when staff had time to spend with people we heard laughing and joking in the lounge. Another person told us "They are kind you can tell how they speak to you". People all gave us positive feedback about how staff treated them with kindness and compassion and we saw people and their relatives felt comfortable in the company of staff and the registered manager. We saw when staff spoke with people they responded in a kind manner, which made people, feel comforted and happy. We saw positive relationships had developed between staff and people at Bush Rest Home.

Inadequate

Our findings

At our inspection in 2016, we rated the provider as "requires improvement" in this key question. This was because the system operated by the provider did not ensure people had access to activities to spend their leisure time. At this inspection, we found the required improvements had not been made and the care people received had deteriorated which meant they were no longer meeting the requirements of the law.

People were not always supported to have care in the way they preferred or which was responsive to their needs. People told us they were bored and did not have sufficient opportunities in how they chose to spend their time. One person said, "'I really enjoy painting but they don't do it here. I'm not sure if they have any paint. I do get bored sometimes". Another person commented, "'I used to love cooking I miss doing things now sitting around makes me feel tired. I do worry as it gets me down everything is done for you". People told us about their personal hobbies and interests and how they would like to spend their time doing some of the activities they used to enjoy. For example, two people told us they used to enjoy knitting but they had not been given the opportunity to do this in Bush Rest Home. Staff told us they knew how people preferred to have their care but we saw staff did not always have the time to spend with people. Our observations demonstrated people spent most of their time chatting to each other, or watching the television with little or no other alternatives offered. We saw the environment was not conducive to people enjoying the television. We saw the registered manager had not considered people's individual needs. We heard two televisions and a radio all playing at the same time in different areas of the lounge that could all be heard by people at the same time. This is difficult for people living with dementia to understand and may cause further confusion to them. Records we saw demonstrated staff had collected some information about people's interests and hobbies; however, they had not implemented this information into how people spent their time on a daily basis at Bush Rest Home. We spoke with the registered manager about how people's individual needs were considered in their care. They told us they had been concentrating on other findings at our previous inspection and would be getting staff to speak to people in how they wanted to spend their time at Bush Rest Home.

We observed people having their lunchtime meal. We saw the food given to people did not always reflect their personal choices and preferences. We saw one person who had chosen to follow a specific diet be given food by a member of staff which would conflict with their individual preference. We saw they ate some of the food offered before another member of staff intervened, advised that this was not a suitable option, and replaced it with the food that had been prepared to meet this person's individual preference. We saw one person was given a plate of food with two items of food which they didn't like. The registered manager replaced the food for this person but commented at the same time they needed to ask people about which

foods they liked and disliked so as staff were aware of their preferred options to ensure staff were aware of people's preferences. This meant people were not supported to have care which was responsive to their individual needs and which reflected their own choices and preferences.

Regulation 9 states the care and treatment of service users must be appropriate; meet their needs and reflect their preferences. The above evidence demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

People were unsure about how to complain should they need to. No one we spoke to knew how to make a complaint or where to find the information should they need to. One person said, "I haven't had to yet". Another person told us, "If I have an opinion I keep it to myself". Another person and their relative told us although they hadn't needed to complain they wouldn't know how to if they did needed to. The registered manager told us no complaints had been received by the service over the last 12 months. Any niggles or concerns that had been reported by people or their relatives that could be sorted out at the time had been, however, these were not recorded anywhere. This meant that any trends that had emerged would not be identified or any corrective action taken by the provider to ensure there were no repetition of any of the concerns brought to the staff or registered manager. We looked at the system in place to ensure people and their relatives knew how to complain. We found the system operated by the provider meant people and their relatives could not easily access the information they needed to ensure they knew how to make a complaint should they need to. We saw the complaints system included an easy read version of the complaints policy designed specifically for people who used the service, however it was stored in a folder in the reception area of the service. The complaints policy was also stored in the same place so was not accessible for people who use the service and their relatives to access. The complaints policy was brief in its content and did not offer the potential complainant clear instructions on what they needed to do to make a complaint and what to expect when they did. The registered manager told us they were reviewing and updating the policy following our inspection. We found people weren't empowered to share their views and opinions of the care they received and did not know how to complain should they need to.

Regulation 16 states the registered person must establish and operate effectively an accessible system for identifying, receiving, recording and responding to complaints by service users and other person's in relation to the carrying on of the regulated activity. The above evidence demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

The registered manager told us no one living at Bust Rest Home at the time of our inspection was being supported at the end of their life. However, they told us they had an end of care plan they would follow and with the support of the district nurses in the community, they were able to support someone to have a comfortable, dignified, and pain free death.

Inadequate

Our findings

At our inspection in 2016 we rated the provider as "requires improvement" in this key question. This was because the system operated by the provider did not ensure people were involved in the development of the service and the quality assurance system used by the provider was not effective .At this inspection we found the required improvements had not been made. The provider was not now meeting the regulations around the effective management of the service.

The registered manager was aware of some of their legal responsibilities as a registered person with the Care Quality Commission (CQC). Organisations registered with the CQC also have a legal responsibility to notify us about certain events and about incidents that had taken place. The provider had ensured that notifications had been submitted to the CQC as required by law. However, registered providers are legally required to display the ratings awarded by the CQC. We noted on the second day of our inspection the provider had failed to ensure the rating of the service following our inspection in September 2016 was displayed in the premises. We saw the report following our previous inspection was filed in a folder in the reception area of the service but was not on display. We noted however, the provider had displayed the rating on their website. On the third day of our inspection, the provider had displayed the certificate which shows the rating of the previous inspection in on the wall of the registered manager's office. However, this was not, as the regulation states "should be displayed conspicuously in a place which is accessible to service users". We asked the registered manager why it had not been displayed and they told us they were not aware of the need to display the information. The provider had failed to ensure the rating had been displayed as required by law.

This meant they were in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirement as to display of performance assessment.

The provider and registered manager had failed to develop an effective quality assurance system. The system in place did not identify risks to people and areas of improvement required in the service. We saw numerous areas of concern with regards to the care people received and the registered manager had failed to identify and improve the quality of the care. We saw the system in place consisted of audits of people's medicines but they were ineffective as they only looked at a small proportion of people's medicines and did not identify the areas we did during our inspection. For example, we saw gaps in people's medicine charts and staff could not explain to us why or if people had received their prescribed medicines. The system in place did not identify risks to people and areas of improvement required in the service, which had resulted in some people sustaining further weight loss and no action had been taken when necessary. For example,

one person who was at risk of weight loss had not been weighed as per their care plan, and they had lost weight and the system in place did not recognise this and the person had sustained weight loss. We saw numerous areas of concern with regards to the care people received. For example, the registered manager had failed to identify and improve the quality of the care people received when people mobilised. One person was moved using an unsafe technique and the system in place had not ensured staff had the skills to recognise this unsafe procedure which meant the person was at risk of sustaining injuries. We saw lessons had not been learnt when people had had falls to ensure they weren't repeated. We found improvements were needed in the recruitment system operated by the provider. We found the system in place had not ensured staff were competent in their role and had the skills and knowledge to recognise poor or unsafe care. We found records about people's care were not always up to date and did not contain relevant information for staff to follow. This meant that people were receiving inconsistent care and support that was not provided according to their individual preferences and needs. We found people's choices with regards to their likes, dislikes and what food they preferred had not been collated, and we saw one person given food they didn't like. We found the provider and registered manager had not ensured people were involved in their care. For example, one person had bed rails and they had not been consulted about this. We found staff were not aware of which people were deprived of their liberty and why, which may result in people receiving inconsistent care. The registered manager had not always considered people's dignity when care was given. For example, people were weighed in a public area and staff had not considered their dignity. The system in place had not recognised this. We found people were not always in receipt of personalised care which was responsive to their own needs. For example, people had not been asked how they would like to spend their time at Bush Rest Home and this had resulted in people being bored. The complaints system operated by the provider was not easily accessible to people who use the service and their relatives and people told us they did not know how to complain.

When we highlighted some of our concerns with regards to the care one person at Bush Rest Home had received the registered manager was concerned about not meeting the person's needs. The registered manager recognised the system in place had not highlighted the failings which meant they were not meeting the person's care needs at all due to the failings in the system operated by the provider. They told us they had concentrated on some of the areas highlighted in our previous report such as infection control which meant they had failed to identify other areas where improvements were required. The registered manager told us they were aware the governance system operated by the provider needed to be updated and include further areas such as care records and observations of staff to improve the care people received and to ensure the care people at Bush Rest Home received was safe. However, despite being aware of this the registered manager had not acknowledged the significant impact these failing were having upon people in the home. People were exposed to the risk of harm as a result in the failure of the registered manager and provider to implement an appropriately robust governance system.

Regulation 17 states systems or processes must be established and operated effectively to assess, monitor, and improve the quality and safety of the people who use the service. The above evidence means the provider is in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some areas of the governance system were effective, for example, the environment was clean and tidy and mattress audits had highlighted two mattresses needed replacing and these had been replaced prior to our inspection

We found improvements were required in how the home was led and how the provider ensured leaders in the organisation were skilled and had the knowledge to promote positive ideas and culture from within, and how the staff were motivated to encourage positive practices within the home. For example, when we asked

staff about where people were weighed they told us the scales had always been there and no one had questioned this. When we intervened staff thought this was a positive suggestion and agreed people's dignity had not been considered. We saw practices within the home had been in place over many years and there was no driving force to encourage staff to develop new skills and expand in their role. We found the culture in the home was to accept how things have always been completed and not to challenge new ways of working. We found staff concentrated on tasks and sometimes that meant people went without choices in their every day care needs. The registered manager told us they would be spending time on developing staff to have more input in how the home was run which will have a positive impact on the people who live there. The registered manager told us other than internal meetings with other managers in the organisation they spent no other time developing their own skills to ensure they were up to date with current practice. We saw the registered manager and provider had not developed strategies in order to move the service forward and give staff a clear vision in how they saw the home would move forward to ensure people living there received safe, effective and responsive care to meet their individual needs. The registered manager told us their focus going forward was to ensure the service improved so the care people received met their needs and was safe. We found improvements were required in the management of the service to ensure people who used it received better outcomes.

We received mixed views about whether the home was led. One person told us, "I have a laugh with the manager the home is well led". Another commented, "'Manager and staff are approachable you can talk to them". However, one person told us, "I'm not asked my opinion" and a fourth person said, "I don't know the manager". We saw residents meetings were held to gain opinions from people, however we saw when suggestions had been made no action had been taken to put the ideas into practice. Staff told us they felt supported by the registered manager and since they started and the atmosphere had improved in the home. Staff told us they had regular meetings to discuss people and the support they required. Although one member of staff told us they had made a suggestion about one person's care and the registered manager had implemented this, we saw no evidence to suggest staff were encouraged to make suggestions to improve the quality of the service. Meetings took place at different management levels. Although the registered manager told us they had an infection control champion amongst staff no other areas of care were championed by staff. The registered manager told us they would involve staff more following our inspection to look at areas such as dementia care in the home.

Although staff told us they received regular feedback in supervisions and areas where they could improve, we found that staff did not always have the skills to support people. One member of staff told us they thought the management structure needed to be reviewed as in their opinion there were "too many chiefs and not enough Indians". The registered manager explained to us the management structure had not been reviewed in the home for many years. We found errors made by senior staff and the registered manager had not addressed these. For example, a senior member of staff who had the responsibility to ensure the rest of the staff moved people safely used an unsafe technique to move a person we saw at Bush Rest Home. We found significant concerns in how people living at Bush Rest Home received poor care. The poor quality of the care and the culture within the home had not been recognised by the leadership and governance which meant people had received unsafe, ineffective, uncaring and care which did not meet their individual needs. The registered manager told us following our inspection they would be spending more time on the floor observing staff to monitor how care was delivered on a daily basis so any gaps in staff skills and knowledge could be addressed with further training. They also told us the management structure was under review at Bush Rest Home to ensure people living there received better outcomes. We spoke to the registered manager about how they furthered their knowledge and skills and how they kept up to date with current practice. They told us other than meeting with other managers within the organisation they did not have any other methods of keeping up to date with current practice. We asked about what the plans to develop and move the home on in the future. They told us they would be working on the deficiencies in their systems our

inspection had highlighted in the hope of gaining a better rating in the future and on improving the care people received at Bush Rest Home.

The registered manager told us they worked with other professionals and had regular visits from the Local Authority to complete audits. They explained they operated in an open and transparent way which meant good relationships had developed. During our inspection we found staff and the registered manager open and willing to listen where errors had been made and showed a willingness to learn and to move the service forward in a positive direction.