Bush Home Limited

Bush Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this home on 6 and 8 September. This was an unannounced Inspection. The home was registered to provide residential care and accommodation for up to 44 older people. At the time of our inspection 35 people were living at the home. We found that while there had been some concerns raised prior to the inspection about the home, but we found that there was evidence that things were improving.

The registered manager was present during our inspection. They had only started work at the home two months before 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.

People we spoke with told us that they felt safe living at the home and relatives we spoke with confirmed this. We found that staff knew how to recognise when people might be at risk of harm and were aware of the registered provider's procedures for reporting any concerns.

At the time of our inspection there were adequate staffing levels to meet people's individual needs. People were supported by staff who had received training and had been supported to obtain qualifications. This ensured that the care provided was safe and followed best practice guidelines. Recruitment checks were in place to ensure new staff were suitable to work with people who needed support.

Most people received their medicines as prescribed; however, medications that were needed by people 'as required' were given by staff who did not always have the information they would need to administer these safely and consistently.

People's needs had been assessed and written in care plans, however these were not person centred and did not inform staff how to support people in the way they preferred. Measures had been put into place to ensure risks were managed, but these had not been regularly updated or amended when people's needs changed.

People's nutritional and dietary needs had been assessed and people were supported to eat sufficient amounts to maintain good health. People were not always supported to have enough fluids to drink to keep them comfortable and well hydrated. We recommend that advice about nutritious food and drinks for older people is sought. People were supported to have access to a wide range of health care professionals.

Staff we spoke with had some knowledge of the requirements of providing care that upholds people's legal rights, but were unable to consistently tell us how they uphold the rights of people who did not have capacity to make their own choices. We saw that staff did not always ask people to consent to their care on day to day issues. The registered manager had plans to review people's consent in respect of many areas within people's care. Some necessary applications to apply for Deprivation of Liberty Safeguards (DoLS) to

protect the rights of people had been submitted to the local supervisory body for authorisation.

People told us that they were happy living at the home. We saw that staff treated people with respect and communicated well with people. People told us they wanted to go out more in their local communities. Some people were not offered the choice of social activities and had very limited access to activities within the home itself. People did not always have their dignity upheld.

There was a complaints procedure in place, and people told us they knew who to speak to if they had any concerns. Relatives told us they knew how to raise any complaints and were confident that they would be addressed.

We found there were ineffective systems in place to monitor and improve the quality of the service provided. The systems that were in place had not been effective in ensuring the home was consistently well led and compliant with the regulations. These were being improved by the registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were at risk of not being supported as needed when their needs had changed.

People could not always be sure they received their 'as required' medicines as prescribed.

People could be confident that the majority of their medicines were stored and administered safely.

Accidents and incidents were managed well.

People felt safe and were supported by adequate number of staff who had been trained to recognise and report signs of abuse

Is the service effective?

Requires Improvement

The service was not always effective.

People were provided with food they enjoyed, and had support to eat, however people did not have sufficient drinks made available to them at all times.

People could not be certain their human rights and personal liberty would be upheld as staff did not provide care in line with the principles of the Mental Capacity Act.

People had good access to health care.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not supported to be involved in their care, or helped to make decisions.

People were supported by staff that were kind and caring

People did not always have their dignity respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not supported to contribute to their care plans.

People's wishes and preferences were not consistently sought and acted upon.

People knew that they could complain and they would be listened to, but were not aware of the system to do so.

When people began using the service they had an assessment that meant the service could support them.

Is the service well-led?

Requires Improvement

The service was not always well led.

People had not been included in developing the service. There were very few effective quality assurance processes in place to drive improvements.

There was a registered manager newly in post who had made positive contributions to the home and developing systems and audits to drive up improvement.

The registered manager was well liked and considered approachable by people, their relatives and staff.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 8 September 2016 and was unannounced. The inspection team comprised of one 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.

As part of planning the inspection we checked if the provider had sent us any notifications. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We used this information to plan what areas we were going to focus on during our inspection visit.

Before the inspection the provider was asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also 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 took this into account when we made the judgements in this report.
During our inspection we spoke with ten people who lived at the home, nine relatives and four care staff. We spoke with the registered manager and the nominated individual who was also the owner of the home. We also spoke with four health professionals after the inspection visit.

We reviewed some aspects of the care records of three people who lived at the home and medication administration records to see if people were receiving their care as planned. We sampled three staff files including the recruitment process. We sampled records about training plans, service user feedback and looked at the registered providers quality assurance and audit records to see how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People and relatives felt that they were safe living at the home. People told us, "They try to give me my medication on time." and "It's really nice here." Relatives told us that that although staff seemed busy they felt that people were safe and well looked after. A member of staff told us, "I think people are safe here."

Staff we spoke with knew about people's individual risks and actions they would take to keep people safe while not restricting their freedom. We saw people used different aids, such as hoists, walking frames and sticks. Staff made sure that people's specific aids were placed within easy reach of them. We did note however that one person who needed to have their legs raised had not been provided with the stool to do that. On the days of our inspection we observed moving and handling activities. There was good interaction between staff and people and people were reassured as the transfers were taking place. We saw that on two occasions equipment was not secured before the transfer began and on one occasion a person was left in an undignified position as the staff had not prepared their wheelchair for them before beginning the manoeuvre.

We looked at three people's care files in detail. These included risk assessments around many areas, such as personal care and manual handling. The risk assessments were specific to each person, but not all of them had been regularly reviewed or amended when people's needs had changed. We saw that one person had history of falls, but their risk assessment in relation to moving about the home had not been updated to reflect this risk and action staff were to take to help to keep them safe. A member of staff told us, "I don't think some staff do understand the risks to [people]." This meant that people did not always receive safe care that was in line with their current needs.

Emergency situations had been considered. The registered manager and staff told us that fire drills took place and that smoke alarms were tested. Staff we spoke with were consistent in their response about what action to take in the event of a fire or an emergency situation. However, evacuation plans were not in place for each person to detail whether people needed equipment to mobilise, or other support they might require to evacuate quickly and safely. This meant that some people would not be kept safe in the event of an emergency. We brought this to the attention of the registered manager who said that they planned to introduce the evacuation plans.

Staff knew what constituted abuse and what to do if they suspected someone was being abused. All the members of staff we spoke with had received safeguarding training and were able to identify the types of abuse people receiving care and support were at risk from. They knew how to report their concerns to the registered manager or external agencies such as the Care Quality Commission or the Local Authority. Staff we spoke with could confidently describe the different signs and symptoms that a person might present which would indicate they were being abused. The registered manager had a good understanding of their responsibilities in maintaining the safety of people from harm. They had notified us about any concerns they had in relation to people's safety which included any incidents of potential abuse or serious injury to people. This meant that people were kept safe.

Records confirmed that there were procedures in place to record when accidents and incidents had occurred. These had been analysed and appropriate steps had been taken to reduce the likelihood of similar incidents happening again in future. We saw that actions had been taken in a timely manner to keep people safe.

We looked at how the home was staffed. A person told us, "There's not always enough staff on duty." Relatives gave us mixed views about staffing numbers. One relative said, "Staff are good but they don't have the time ." The relative went on to say that staff did not have time to spend with people other than to complete tasks. However another relative told us, "There's always enough staff to respond to the residents." The registered manager told us that although the shifts were covered to the agreed staffing numbers, the home was in the process of recruiting more staff, as existing staff were doing extra shifts to cover the rota. We saw that the registered manager used a set method to identify and make sure there were sufficient numbers of staff and we noted during our inspection that the correct number of staff calculated as necessary were on duty. During our inspection people did not wait for long periods of time when they requested some support. A relative said, "We have never seen anyone be left, if there's a problem the staff are there straight away."

Robust recruitment processes were in place to help minimise the risks of employing unsuitable staff. We reviewed staff recruitment files and saw that the registered provider's recruitment process contained the relevant checks before staff worked with people. Staff told us that the provider had taken up references about them and they had been interviewed as part of the recruitment and selection process. One member of staff said, "Staff have their DBS checks done and shadow for a minimum for two weeks." The registered manager showed us that there was a system for making sure background checks were regularly reviewed.

Medicines were ordered and delivered in good time to the home and we saw that medicines were kept in a suitable safe location. We observed a member of staff preparing and administrating people's medicines. We saw the staff member informing people about their medicines and asking if they required any pain relief medication as appropriate. Medicines were administered in a safe and unrushed manner.

Staff supported people to have their medicines from monitored dosage systems (blister packs) to minimise the risk of errors. We noted that the new medicines room was well ordered and contained a separate locked cabinet and refrigerator so that certain medicines could be stored safely.

We looked at the medication administration recording sheets (MARS) and saw that they had been completed well. Where medicines were prescribed to be administered 'as required', there were inconsistencies in the availability of instructions for staff. These instructions provided information about the person's symptoms and conditions which would alert the staff to when the 'as required' should be administered. We found that some people who were not able to tell staff what medication they needed, had instructions for staff to follow and others did not. This meant that people may not have received their medication when they needed it.

Most of the staff who administered medication were trained to do so. Staff told us that they had been trained but were unsure of when the training took place. Records we sampled did not consistently support that staff had up to date training in relation to medication. The registered manager did not have a system to check that staff continued to be competent to administer medication. When we spoke with staff about their understanding of some aspects of administering medication safely, we found that not all staff had current knowledge. For example two staff told us that they would not report missed medication to a health professional for three days. When questioned the staff explained that this was what they had been taught to do. Before we left the visit the registered manager told us of their plans to rectify this situation.

We found that some aspects of administering medication were not safe. Medicine Administration Records (MAR) had not been subject to regular audits prior to the new registered manager starting to work at the home. Since that time however we saw that audits had begun and corrective actions had been put in place. A sample of audits confirmed this. After the inspection visit we received information from the local pharmacy that supplied and supported the home. An audit they had completed supported our findings that medication had not consistently been administered safely.

Requires Improvement

Is the service effective?

Our findings

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

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. The registered manager demonstrated that they were aware of the requirements in relation to the Mental Capacity Act, (MCA), and the Deprivation of Liberty Safeguards, (DoLS). We saw that the registered manager had sought and taken appropriate advice in relation to people in the home.

Staff were not able to consistently explain how they supported people in line with the principles of the MCA. Care records did not show evidence of consent or decisions being made in people's best interests. Staff we spoke with were not sure if anyone was allowed to leave the building unaccompanied. This meant that staff did not have accurate information, which may have had a negative impact on people's liberty. One person went out independently but had to ask staff to open the door. We discussed this with the registered manager and they advised us that they had plans to review the arrangements that were in place.

During our inspection we saw that people were involved in the routine daily decisions of the home and were asked for their consent whenever appropriate. One member of staff told us, "I think [staff] are polite, we always ask people what they want." We observed that staff were skilled and knowledgeable in how to do this to ensure the best outcome for the people they were supporting.

We talked with people about how the skills and abilities of staff, and if they delivered effective care. People and relatives we spoke with said that the staff understood their roles and supported them well. One person said, "The care is very good actually." Another person commented, "Staff look after us fine." A relative told us, "I've been satisfied, [my relative] is very happy here. They have looked after her well." A health professional who visited very often said, "People are fine here, there's no concerns for people."

We observed people being supported at lunch time and saw that some people had to wait up to an hour for their meal, while sitting at the dining table. This situation did not improve on the second day of our inspection. One person said, "I'm hungry but I've still got to wait." Other people commented, "No choice of meal." and "If you don't like the meal you leave it, nothing else is offered." and "Meals vary, the food's okay." People who required assistance with eating were appropriately helped by staff. We saw that some people had been provided with cutlery that was easy to hold and plates with guards on them so that people could maintain their independence as much as possible.

Menus were not available to assist people in making a choice about food they wanted, but a member of staff asked each person in the morning what they would like to eat at lunch time. When the meal was actually served however, no other choice was offered. When one person did not eat their meal they were offered toast as an alternative. There was no evidence of fruit or other snacks being available to people other than at set times when they were offered by staff. The mealtime was interrupted by a medication round, and not all people appeared to have a pleasant or enjoyable lunchtime experience. The registered manager told us that they planned to introduce new foods on the menu that some people had requested. These included dishes that were special to the local area and that people had enjoyed while growing up.

Staff told us that people were given drinks at set times during the day from the 'tea trolley'. During our visit we noted that people were not offered anything to drink between breakfast, which people had between 7 and 9am, until 11.30am , and there was supplied of drinks available for people to help themselves and there was no obvious method of people being supported to access drinks themselves. We asked a member of staff to offer drinks to people who we saw drank them very readily indicating that they were thirsty. One person told us, "Drinks are few and far between." And "You only get drinks at set times." A relative commented, "[People] are not allowed much to drink, it's only given at a certain time and if people ask for a drink they are told to wait." We looked at the fluid monitoring charts of one person who was unwell. The recording was not consistent and had not been added up to calculate the total amount of fluids the person had drunk that day. There was no evidence that action had been taken when the person did not drink enough. A health professional we spoke with confirmed that the home did not regularly add up the fluid intake for people and did not act on any concerns raised. We brought this to the attention of the registered manager who told us they would rectify the situation. We recommend that the registered manager seek advice and guidance from a healthcare professional or a reputable source about the provision of nutritious food and drinks for older people with the aim of improving the selection of food available and ensuring people receive enough fluid to maintain good health and to meet their preferences.

People living at the home had a range of health conditions and were supported to stay healthy and access support and advice from healthcare professionals when this was required. We spoke with three health and social care professionals following our inspection visit, who gave positive comments that the people who lived at the home were supported to maintain their health. Comments included, "The staff are aware of [people] and their conditions, they always follow my instructions." And "The staff monitor people quite well, take their weights and give the supplements well. One person had a weight loss but its back up now, the person is much better." Records confirmed that people had suitable access to health care as they needed it.

Staff told us that they received an induction which included getting to know people's needs and shadow more established staff. One member of staff told us, "The induction was good, about how stuff was run. I had a mentor and did all the shadowing." The registered manager told us that the Care Certificate [a nationally recognised induction programme for new staff], had recently been introduced for new staff. Staff we spoke with confirmed this. This meant that people could be sure that staff knew how to support them well.

Staff we spoke with told us that there was a variety of training and qualifications offered to them and they spoke positively about the training. One member of staff said, "I've had my training and recently we have been having work booklets." Staff we spoke with told us that they understood training was an important aspect of their role. We looked at staff training records and saw that he registered manager had an effective system to ensure all staff received the core training they needed to allow them to carry out their role well.

Supervision is used to reflect on the care practices of staff and to enable them to care and support people effectively. Staff we spoke with told us that they had not received regular supervision until the new

registered manager had come into post. Staff told us, "I do feel supported now with the new manager. Another member of staff said, "The seniors are approachable but I've not had supervision." We saw that supervisions had been scheduled for the rest of the year by the registered manager.

Staff participated and contributed to handovers between shifts to support continuity of care and provide the best possible outcome for people. Staff we spoke with told us that communication was effective within the team. One member of staff said, "I think the staff are brilliant, we work well together." The provider had suitable management on-call rotas in place to support staff when they required advice and guidance.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were generally positive about the caring nature of the staff team. One person told us, "The care is smashing, they are very good." Another person told us, "The care is alright, the staff are nice." However another person told us, "We get more support from each other [rather] than [the staff]." Relatives were complimentary about the staff team. One relative told us, "They spend time with [my relative], they seem kind. When she was in hospital they visited her." People told us that their visitors could visit at any time and that staff made visitors feel welcome. We saw that visitors came and went at various times throughout the day.

During our visit we spent time in the communal areas and saw that staff interacted with people in a warm and kind way. We saw staff respond to people's attempts to communicate in a timely, supportive and dignified manner. There was a friendly and relaxed atmosphere within the home. We saw staff sitting with people and they provided comfort and support to people. When one person became very distressed we saw a kind and caring example of support being offered immediately. We observed positive and respectful interactions between people and staff. A member of staff told us, "I'd say that staff really do care about the residents."

We observed staff often checked with people before providing physical care and respected their choices, however this practice was not consistent among the staff team. During our observations we saw that some staff did not always ask people what they wanted when they were offering support. For example one person was told when it was time to go to the toilet, and not asked. This happened as the person was being pushed in their wheelchair to the bathroom. Other examples included people not consistently being asked what type of drink they wanted or where they wanted to sit or be in the home. While staff could often describe what people liked and preferred, we did not see day to day choices being given. One person told us they wanted their main meal in the evening and only a light lunch. The person told us that this had not happened, and we saw that they were given their main meal at lunch time. This meant that people's choices were not taken into account as much as they may have wished to have been.

Care records had not been written in a way that gathered information about people's choices or preferences. People did not have access to other systems that might have enabled them to be more actively involved in planning or reviewing their care, such as residents meetings. We saw that care plans were regularly reviewed, but found that they were not read by care staff. One member of staff told us, "I think I've read one care plan." People were not involved in the planning of their care. We saw that one person who was distressed. They had recently moved in. We noted that the member of staff who went to comfort the person did not know their name. We saw that records did not describe what people liked to do, or what their interests or hobbies were. The records did not include any information relating to the person's life history. When we spoke with staff we found that they had learnt about some people's choices and preferences as they had cared for them for a long time. Staff we spoke with had some knowledge of people they cared for and consistently spoke fondly and respectfully about people they supported. This meant that people did not always receive care that was based on their expressed views and wishes.

We saw that staff usually treated people with respect and dignity. One staff member told us, "The door is always shut for personal care, and we try to offer same sex carers – but that's not in their care plan." Rooms that we had been invited to see had been personalised with people's photographs and ornaments which all assisted people to feel relaxed and at home. We saw that people moved about the communal areas freely and enjoyed going into the garden. On one occasion however we saw that a person was left hanging in a hoist for over 5 minutes as staff were not ready to complete the transfer of the person. The registered manager told us that people were not routinely offered a key to their own bedrooms and that during the day time the rooms were locked for security reasons. Staff told us that people asked if they wanted to go into their bedrooms and they opened the room for them. One person told us they did have a key to their room because they had asked for it. People's capacity to have a key and use it safely had not been considered, which meant that some people were not treated with respect in relation to being given the opportunity to have keys to their bedrooms.

Requires Improvement

Is the service responsive?

Our findings

People told us that they did not have enough to do that offered them meaningful activities and interest. Comments included, "Once you are up, you are in your chair, all we do all day is sit and watch TV." and, "I miss going out, I loved shopping." and "No one sits and asks you what you are interested in, there's nothing to do here." Another person said, "They let you get on with things here, I don't get bored." A relative told us, "They do parties for birthdays and Christmas." We observed that staff were usually caring but were mostly orientated to completing tasks rather than having meaningful interaction with people. We spoke with the registered manager who told us that they had set up a plan of activities that included arranging for sessional activities to be delivered in the home. This plan had recently begun and on the day of our inspection people who had chosen to take part, enjoyed a gentle exercise session.

The registered manager told us and records showed that initial assessments had taken place to identify people's individual support needs. This made sure that the home knew they could provide the correct support to people. We found that people did not contribute in a meaningful way to their plans of care or their reviews. While staff knew people well, their records did not reflect their individual choices and preferences to tell new staff or temporary staff how to support the person as they preferred. When people expressed choices they were not always supported to achieve them. For example one person liked to garden and we saw that they attempted to do so with a stick and a bin lid. Staff told us they knew the person liked to garden but that had not helped them get appropriate equipment. Peoples care was not person centred and did not reflect their individual wishes. There was no evidence within the home that people with various religious beliefs or cultural choices had these needs met. The registered manager told us they recognised the need to be more responsive to people's individual needs and aspirations.

People and their relatives told us that they felt that complaints and concerns would be dealt with well. However no one we spoke with was aware of the homes formal complaints policy or where to read it. All the relatives we spoke with told us they would speak to the manager if they had any concerns. One relative said, "I would speak to the manager if I needed to complain, but there's no complaints policy."

All the staff we spoke with had a good understanding of how to support people and others if they wished to complain. The registered manager was aware of their responsibilities in relation to the duty of candour. This meant that they knew their legal responsibilities and were therefore open and transparent when things went wrong. We saw that the provider had a formal complaints procedure and we noted that the home had received complaints which had been dealt with appropriately. The registered manager told us the importance of resolving complaints and then more importantly learning lessons from them to prevent any recurrence. This meant that people and their loved ones could be reassured that concerns and complaints were listened to, acted upon and processes put in place to reduce the likelihood of negative events recurring.

Requires Improvement

Is the service well-led?

Our findings

People did not receive care that was always person centred and that listened to and acted upon peoples expressed wishes. Staff practices were not consistently effective or responsive to the individual needs of people who lived at the home. For example in relation to people having individualised care and access to sufficient drinks.

We looked at the arrangements the provider and registered manager had in place to drive through improvements in staff practice so that people would consistently receive effective and responsive care. Whilst people had not benefitted from a service that had always been well led, we saw that new systems to improve this were being introduced at the home.

The registered manager had introduced new auditing tools, which because of their short time working at the home had not yet been fully implemented. The auditing tools to be introduced covered a broad range of issues.

People had not been consulted with about their care and support in relation to their wishes and choices. People did not have access to residents meetings or other systems to ensure their voice was heard. People had not been routinely involved in their care planning or in how the home was run. For example one person chose to sit in a seat by an open door. They told us that it was draughty there and they wished the door could be closed. Staff said the person had sat there with the open door for many months. We brought this to the attention of the registered manager who spoke with the person and arranged for them to be made more comfortable.

Peoples' care plans were not reviewed with their involvement where they were able to contribute. Relative's opinions had also not always been taken into consideration. Surveys had not been carried out to gain the feedback and opinion of people or their relatives. There were no other processes in place that helped to ensure that people were at the centre of their care and support, and that their voice was heard.

There were mixed responses from people, relatives and staff we spoke with about how well led they felt the home was. A person told us, "Some staff are good, but some let them down." A relative told us, "I haven't got any gripes." and a professional said, "I have no problems here." The registered manager had been in post for a few months and the staff we spoke with consistently praised her and their staff colleagues. Staff said, "[The registered manager] is really pulling things together, she's hands on and it makes it a happier place, it's really improved." and "[The registered manager] is making good improvements, I feel comfortable talking to her, she gets things done." Other staff spoke of how well they thought the team worked together. Comments included, "I think the staff are brilliant, we work well together." and "The staff really help each other out." This meant that the leadership within in the home was perceived as improving.

Health and social care professionals spoken with said that felt the home was improving . The registered manager met their legal requirements and notified us about events that they were required to by law. There was a leadership structure that staff understood.