Care Quality Commission

Bupa Care Homes (CFC Homes) Limited

The Red House Residential and Nursing 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

The Red House Residential and Nursing Home provides accommodation, personal care and nursing care for up to 60 older people including those living with dementia. Accommodation is located over two floors and there is a separate house (annexe) that accommodates 12 people. There were 54 people living in the home when we inspected.

This inspection was undertaken on 9 February 2015 and was unannounced, Our previous inspection was undertaken on 13 August 2014, and during this inspection there were breaches of four regulations. These were in relation to respecting and involving people, staffing, quality assurance and records. The provider sent us an action plan detailing how they would meet these regulations. During this inspection we found that improvements in these areas had been made.

The home did not have a registered manager in post. The registered manager left their post in October 2014. A

Summary of findings

registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

The CQC monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which applies to care services. We saw that there were policies and procedures in relation to the MCA and DoLS to ensure that people who could not make decisions for themselves were protected. We saw that staff had followed guidance and were knowledgeable about submitting applications to the appropriate agencies. Records viewed showed us that where people lacked the capacity to make decisions they were supported to make decisions that were in their best interests. People were only deprived of their liberty where this was lawful.

Improvements were required in relation to the administration and recording of medicines to ensure that an accurate record is kept as people were not at risk of receiving the incorrect dose.

There was a process in place to ensure that people's health care needs were assessed. This helped ensure that care was planned and delivered to meet people's needs safely and effectively. Staff knew people's needs well and how to meet these. People were provided with sufficient quantities to eat and drink.

People's privacy and dignity was respected at all times. Staff were seen to knock on the person's bedroom door and wait for a response before entering. They also ensured that people's dignity was protected when they were providing a person's care. There was a lack of activities in the main house.

The provider had an effective complaints process in place which was accessible to people, relatives and others who used or visited the service.

The provider had a robust recruitment process in place. Staff were only employed within the home after all essential safety checks had been satisfactorily completed.

The provider had effective quality assurance systems in place to identify areas for improvement and appropriate action to address any identified concerns. Audits, completed by the provider and interim manager and subsequent actions taken, helped drive improvements in the home.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Although there were appropriate arrangements in place for the storage of medication there was a risk that people may not receive all of their medicines as prescribed.

There were sufficient numbers of staff with the appropriate skills to keep people safe and meet their assessed needs.

Staff were only employed after all the essential pre-employment checks had been satisfactorily completed.

Requires Improvement

Is the service effective?
The service was not always effective.

Improvements were needed to ensure that people were not being deprived of their liberty unnecessarily. Staff were aware of their responsibilities in respect of the Mental Capacity Act 2005 (MCA).

People were cared for by staff who had received training to provide them with the care that they required.

People's health and nutritional needs were effectively met. They were provided with a balanced diet and staff were aware of their dietary needs.

Requires Improvement

Is the service caring?
The service was caring.

Staff treated people with respect and were knowledgeable about people's needs and preferences.

Relatives were positive about the care and support provided by staff.

Good

Is the service responsive?
The service was not always responsive.

Although there were activities on off these were limited.

Relatives were kept very well informed about anything affecting their family member.

People's complaints were thoroughly investigated and responded to

Requires Improvement

Is the service well-led?
The service was well led

There were opportunities for people and staff to express their views about the service via meetings and surveys.

Good

Summary of findings

A number of systems had been established to monitor and review the quality of the service provided to people to ensure they received a good standard of care.

A service improvement plan had been developed to ensure that people are receiving a quality service.

The Red House Residential and Nursing 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 9 February 2015 and was completed by two inspectors and a specialist advisor, who had specialist knowledge in pressure care and infection control. This was an unannounced inspection.

Before our inspection we looked at information we held about the service including statutory notifications. A statutory notification is information about important events which the provider is required to send us by law. We reviewed all other information sent to us from other stakeholders including local authority commissioners and members of the public.

During the inspection we spoke with 12 people living in the home, the interim manager, the senior nurse, five relatives, two visiting health care professionals and eight staff. Due to the complex communication needs of some of the people living at the care home we were not able to gather their views verbally. We carried out a Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experiences of people who could not talk to us.

We looked at 10 people's care plans. We also looked at other records including medicines administration records, staff meeting minutes, service user quality assurance survey questionnaires, staff recruitment files and training records.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at the home and what they would do if they had any concerns. One person said: "I sure am safe the staff are here to help me when I need them."

Another person said: "Yes, I always feel safe. They [staff] are all so nice". Relatives and visiting health care professionals we spoke with confirmed to us that they had no concerns about people's safety. A relative said: "I have never had a concern when visiting".

People were relaxed and happy in the presence of the staff. We observed staff supporting people to keep them safe by allowing them to be as independent as possible and only intervening when necessary to maintain their safety. For example, a member of staff sat with people in the lounge and observed them and would remind them to take and use their mobility aids when they got up to walk around.

Staff confirmed they had received training in medication administration. People we spoke with told us they received their medication regularly. One person told us: "The staff always ask if I require any pain relief". We found that medicines were stored securely and at the correct temperature. Not all of the medication administration records were complete. The records of medications that were administered when required did not state the times that the medications had been administered. Regular prescribed medicine was recorded appropriately. However, one person who was prescribed two tablets at each dose was only being given one tablet with no reason for this. This meant the person was not receiving their prescribed dose. Staff were not clear why, except that this is what the person asked for. Staff confirmed that no medicine reviews had been conducted with the GP.

The night nurse went off duty and the day nurse did not arrive before completion of the administration of all medicines to people who required them to be administered by a nurse. The senior care worker carried on this task although she was not responsible for administering medicines to people who require nursing care

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On the day of the inspection the nurse who was due on day duty rang in sick. The interim manager tried to cover this with an agency nurse without success. Staff we spoke with told us that usually there were enough staff available to meet people needs.

However at one point during our inspection we observed that one of the members of staff had left the annexe to attend a staff meeting and during this time the second member of staff was providing some individual care and as a result could not answer the door to a visitor or to let a visiting GP leave. This was because the door was locked with a keypad, the number was not available to the inspector and there was no other member of staff available People we spoke to told us that they were unable to open the door as usually staff were around. One person said: "We may sometimes have to wait for staff but they come as soon as they can". We discussed this with the interim manager who said they would look into deployment of staff at meeting times, as other staff such as ancillary staff could be available to respond to the doorbell and be available to respond if people required support. Staff told us that although they were very busy they still had time to care and chat with people. One staff member said: "What I really like about working here are the relationships we develop with our residents, they are so positive". Another staff member said: "I try to create some time during my shift to spend some time with my residents to listen to them".

People's health and safety risk assessments were carried out and measures were taken to minimise these risks. An example included risks of falling out of bed. We found that alternative measures were used, for example, the use of bed rails. In addition, where people had been assessed to be at risk of harm, due to behaviours that challenge others, measures were put in place to minimise these risks. For example when a person's behaviour challenged others there were various distraction techniques available for staff to use. The care records we looked at confirmed that the staff identified when people were at risk and documented individual risk assessments that clearly detailed the risk and the actions taken to minimise the risk. These had been reviewed regularly and were cross referenced to the appropriate care plan.

Staff told us they had been trained to recognise the signs of abuse and they were able to talk confidently about the various forms of abuse. They knew to report any concerns to the manager or a nurse, but were not aware about the

Requires Improvement

Is the service safe?

process of involving and reporting incidents of abuse to the local authority. One staff member said, "I would ask what had been done about any concerns I raised." We did however see information regarding reporting safeguarding concerns to the local authority with the relevant telephone number displayed in the office. Staff told us they would be confident to blow the whistle on bad practice if they observed it. One member of staff said, "I have reported bad practice in the past and it was dealt with."

All but one area of the home were clean and free from malodours. Carpets were being replaced in that area and we were told by the interim manager that it was hoped that this would eliminate the odour. We spoke with two house keepers who were able to demonstrate the cleaning schedules and how they recorded when each area had been cleaned. We found the sluices and cleaning cupboards were tidy and had good stock levels of cleaning equipment and products. All sluices and storage areas were locked securely to protect people from unauthorised access to potentially dangerous chemicals.

Requires Improvement

Is the service effective?

Our findings

Staff had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. Documentation in the care plans indicated staff understood about capacity and how to encourage people to make decisions. MCA documentation had been completed as necessary. We also saw documentation that supported when people should not have cardio-pulmonary resuscitation attempted. These documents had been completed by a GP and involved a family member if the person lacked capacity. We saw that some people were able to consent to making everyday decisions about their care and support needs. For example, what to wear and their preferences about what they would like to eat and drink. Staff we spoke with were confident in discussing the importance of consent to care and told us they always asked people about what support they needed before supporting them. However, for people's safety, in the annexe there was a key pad on the front door. This meant that all of the 12 people living in this area, whether they had capacity or not could not leave the building. We were told by the interim manager that no DoLS applications had been made to support this deprivation. We were told that in the event of a fire the keypad would be over ridden and the door would open so as to allow people to leave the building safely.

Staff told us and the training records we saw showed that staff had received training in a number of topics including fire awareness, infection control, food safety, moving and handling and safeguarding people.

We spoke with a new member of staff and they told us told us they had undertaken a four day induction prior to working at the Red House. They also told us they had a period of shadowing an experienced carer. They said: "At no point did I feel I was expected to do anything I was not happy about". Staff we spoke with told us they had not received supervision for over six months due to their being no permanent manager in place. One care worker said that the interim manager was arranging supervision sessions for all the staff. Another care worker said: "I have not had supervision since taking up a new role a few months ago". All members of staff we spoke with felt they were able to approach the interim manager if they had any concerns and felt supported.

We saw that people were provided with enough to eat and drink. One person said: "The food is lovely. I have no complaints. There is always plenty to eat". Another person said: "I really can't complain. Since I moved in I have been happy with the food. If you fancy something else they always try to sort it out for you". A relative said: "[family member] enjoys their food. Sometimes they need a bit of encouraging, but the staff are very good at that". Another relative told is that people are provided with a choice and they have the opportunity to eat at the home with their family member. We observed people having their lunch within the dining room and noted that the meal time was a relaxed, social event as people were encouraged to come together to eat. However, people could dine in their bedroom if they preferred. We saw that when necessary people received individual assistance from staff to eat their meal in comfort and that their privacy and dignity was maintained. This included people being assisted by staff to use cutlery and having their food softened so it was easier to swallow. Throughout the visit we saw that staff encouraged and supported people to take fluids. It was particularly noticeable that the people cared for in bed or who chose to stay in their bedroom had a drink nearby. Where required, drinks had been fortified appropriately. Soft diets were attractively presented so that each individual component was identifiable. We saw that staff documented the fluid intake of those people at risk of dehydration. People were weighted regularly and we saw any significant loss or gain in weight was correctly acted upon.

People's health records showed that each person was provided with regular health checks. One person told us: "If I need to see a doctor the staff arrange this for me very quickly". Another person said: "I can see a GP if I want and the staff always request a visit if they think I need it". A relative said: "I am confident they would call a GP if [family member] needed them." Staff told us that they attended a handover meeting at the start of the shift where they were given information about people, which included visits people had received from healthcare professionals such as a GP and chiropodist. Staff told us that they would call a GP if a person needed to be visited.

Good

Is the service caring?

Our findings

People were happy with the care provided and told us that they received a good standard of care. One person said: "Staff are all very kind" and another said: "The girls [staff] are good here and help me when I need it they are very kind". We saw that staff showed patience and gave encouragement when supporting people. For example when assisting a person to walk they gave them instructions about how to use their frame correctly and walked alongside them at their pace.

Relatives were confident in the care people received. One said: "As a family I would say we are very happy with the care [family member] receives here. I am always popping in and see how well the staff get on with everyone and they really care about them".

There was a welcoming atmosphere within the home which was reflected in the comments we received from people, their relatives, staff and visiting healthcare professionals. Relatives said that they were able to visit whenever they wanted to. A relative said: "I am always made to feel welcome and get a cuppa when I come in. I can pop in whenever I want to there is no restrictions".

Staff treated people with respect and referred to them by their preferred names, which was documented in their care records. We observed that the relationships between people who lived at the home and staff were positive. One person said, "You can have a laugh with the staff and I like that. I like to dance and staff dance with me". We saw that staff supported people in a patient and encouraging manner around the home. We observed a member of staff showing patience by encouraging and reminding someone where to go for their lunch, allowing them to walk at their own pace and continually reminding them where they were going.

We observed the lunchtime period and when staff assisted people with their food, they allowed them time to enjoy the food and eat at their own pace. As staff served people their meals they said to each person "Enjoy" and reminded them to let them know if they needed anything else. Staff sat with people and chatted whilst they ate their food. People were asked throughout the meal if they had had enough to eat and if would they like anything else

Staff, knocked on bedroom doors before entering and ensured doors were shut when they assisted people with personal care. Staff were knowledgeable about the care people required and the things that were important to them in their lives. They were able to describe what people liked to eat and music they liked to listen to and we saw that people had their wishes respected.

The interim manager was aware that local advocacy services were available to support people if they required assistance. However, we were told that by the interim manager there was no one in the home who currently required support from an advocate Advocates are people who are independent of the home and who support people to raise and communicate their wishes.

We found that some people had chosen to make advance decisions about the care they wanted and did not want to receive. We saw that there were correctly authorised instructions for people who did not want or would not benefit from being resuscitated if their heart suddenly stopped.

Requires Improvement

Is the service responsive?

Our findings

The care plans that we looked at covered areas such as mobility, communication, religious and social needs, continence and nutrition but these did not always reflect people's choices and preferences or make it clear what people were able to do for themselves and then what support they required from staff. However people said that staff knew the support they needed and provided this for them. They said that staff responded to their individual needs for assistance. One person said: "They ask me about my life and how I want things done I feel involved". Another person said: "I can get up and go to bed when I want". Records showed that when people's needs had changed, staff had made appropriate referrals to a healthcare professional and had updated the care plans accordingly. We saw that the outcome of medical appointments had been recorded with any follow up action to be taken. The interim manager told us that the company had introduced new paper work and that all staff would receive additional training and support to ensure that they were clear about what was expected of them.

Risk assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. These had been reviewed and any changes had been recorded.

The interim manager told us how people and their families were encouraged to visit the service before they moved in. This would give them an idea of what it would be like to live at the home and see if their needs could be met.

A relative told us that staff had kept them informed about their (family member's) care so they could be as involved as they wanted to be. They said: "If anything happens, the staff will always call and let us know or update me when I pop in".

There was a lack of activities for some people especially on the upper floor. We spoke with the new activities co-ordinator employed to work in the annexe. They told us they had spent time with each person and found out about their interests and hobbies. They then had planned group and individual sessions which were based on their choices. We noted that people sat in the two communal areas downstairs were sleeping, watching television, reading the newspaper or completing crosswords. We asked one person how they spent their day. They said: "I sit and watch the TV and read the paper. That really is enough for me". Another person said: "I do like to spend time in the garden, when it's warmer. I like to garden and grow things". Other people told us they take part in activities when they are offered. One person said: "Although there is not much been happening at the moment".

Staff told us that they did not always have enough time to support people with activities. One member of staff said: "It would be great to have some members of staff who could spend time chatting with people and doing things rather than just personal care tasks. Another member of staff said: "I would love to take people out for a walk or down to the park, but we don't have time to do it all. Although I always try and have a chat when I can".

There were two communal areas within the service where people could choose to spend time. We noted that appropriate music that people had chosen was playing and one lady was dancing to the music. Staff acknowledged this when they entered the room and a staff member danced with them.

People also had their own bedrooms and had been encouraged to bring in their own items to personalise them. We saw that people had bought in their own furniture, which included small pieces of furniture, photos and paintings.

Everyone we spoke with told us they would be confident speaking to the manager or a member of staff if they had any complaints or concerns about the care provided. One relative told us, "I have no concerns but if I did then I would chat with the manager. They are always around and very approachable and have got things done round here".

The complaints procedure was available in the main reception. The last three formal written complaints that had been made had been investigated by the interim manager and responded to in line with the provider's policy. This meant that people could be assured that their concerns and complaints would be managed in line with the provider's policy.

Good

Is the service well-led?

Our findings

At the time of our inspection there was not a registered manager at the home. The previous manager had left in October 2014. There was an interim manager in post who we were told would be applying to become the registered manager of The Red House. The interim manager had been ensuring people were having their needs met and staff were provided with the support that was required. A staff member told us: "The manager is very supportive and we are able to approach them at any time. He is always openly encouraging suggestions for improvements". One relative told us: "We have had eight managers here in the last 18 months and it has not been good. He [the manager] has been a breath of fresh air and he has done so much in the short time he has been here and we can always go to him and raise any issues we have. We have had a meeting with the big bosses last week and asked that he stays".

We received positive comments from staff, people who lived at the home and relatives about the interim manager and they all told us that he was approachable, fair and communicated well with them. One staff member said "He is fantastic; and works on the floor and sees what's going on and has even been here at the weekends". Another told us, "He listens and ensures we are told things that are important". Another staff member said: "Staff morale has improved and we work well as a team. It is now much better working here".

We found that staff had the opportunity to express their views via staff meetings and handovers.

Staff told us they were encouraged to make suggestions to improve the quality of service provision. They did this either individually in supervision or in one of the regular team meetings. They told us they could now go to both the manager and the deputy manager if they had any problems and felt confident in doing this.

People and their relatives had been given the opportunity to raise their concerns and discuss the management of the home. A meeting had been held the previous week and everyone had expressed their concerns that a further change was to occur within the management of the Red House. Relatives told us they were extremely unhappy and they had been given the opportunity to give their views. A memo was sent to everyone to inform then that the interim manager would now be remaining at the home.

There were a number of systems in place to monitor the quality of service provided to people living at the home. The interim manager conducted a number of monthly audits to assess the service and we viewed audits undertaken covering all aspects of medicines management, fire, health and safety. We saw that where actions had been identified these had been followed up to ensure that action had been taken. The interim manager had also compiled a service improvement plan from areas that have been identified as requiring improvement to provide a quality service.

The interim manager maintained a training record detailing the training completed by all staff. This allowed them to monitor training to make arrangements to provide refresher training as necessary. The staff told us the interim manager regularly 'worked the floor' (this meant he worked alongside the staff in providing care) to ensure staff were implementing their training and to ensure they were delivering good quality care to people. They told us that any issues that were identified in people's care, the interim manager would address them there and then and it was discussed at their supervision.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services were not protected against the risks associated with unsafe administration of medicines This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (f) & (g) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.