Red House Welfare And Housing Society

The Red House Welfare & Housing Society

Inspection report

Meadow Lane
Sudbury
Suffolk
CO10 2TD

Tel: 01787372948

Date of inspection visit:
19 October 2022

Date of publication:
15 December 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Red House Welfare and Housing Society is a residential care home, providing personal care and accommodation for up to 34 people aged 65 and older. The service provides support to older people and people living with dementia. At the time of our inspection 25 people were living in the service.

People's experience of using this service and what we found
The systems in place to assess and mitigate risk were not robust. The governance systems were not sufficient to support the provider and management team to independently identify shortfalls and address them.

Recognition and response to potential risk was not always effective. Environmental risks had not been independently identified and therefore people were at risk of harm. There were gaps in employment processes and records and audits had not identified all the issues found on inspection.

There were sufficient staff on duty to keep people safe. People were kept safe from the risk of abuse and staff understood their safeguarding responsibilities.

The registered manager was transparent and committed to learning lessons when things went wrong and improving the quality of care. Throughout the inspection, the registered manager displayed a candid and transparent approach. They spoke openly about challenges and shared the plans they had in place to address them. They responded to our feedback and were making improvements to the service following the inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 21 December 2019) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This was a planned focused inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all

care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Red House Welfare and Housing Society on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed. We have identified breaches in relation to the governance at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Red House Welfare & Housing Society

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by two inspectors. Following our visit on site an Expert by Experience made telephone calls to people and their relatives to seek their feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return (PIR) prior to this inspection. The PIR is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who lived at The Red House Welfare Society and the relatives of 8 people about their experience and views of the care provided to their family members. We also had contact with 12 members of staff, including care staff, maintenance staff, the administrator, the deputy manager and the registered manager.

We observed people's care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included 5 people's care records and medication records. We looked at a variety of records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

At our last inspection we found the provider had failed to ensure risks to people were mitigated. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 12.

- Environmental risks including potential risks to people's safety were not always picked up and appropriate action taken to ensure people's safety. We found areas of the home poorly maintained with equipment in need of replacement.
- Multiple open stair cases in the building were a concern. The risk of falls on the stairs had not been identified with adequate mitigation put in place. Relevant legislation and best practice had not been considered and implemented, for example Health and Safety Executive (HSE) guidance on Health and Safety in care homes. We signposted the management team to the relevant HSE guidance.
- Environmental risks were not consistently managed. We found several hazards around the building. For example, flooring with rips or trip hazards and rusty equipment. This exposed people to the risk of harm.

The provider and the registered manager failed to assess and effectively mitigate risk to people's health and safety. People were placed at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider had failed to ensure staff were recruited safely. An effective system to ensure all necessary checks on staff were completed before being employed was not in place. The provider did not have oversight of recruitment processes to ensure that fit and proper persons were employed. This failure placed vulnerable people at risk of receiving care from staff who were not of good character.
- We reviewed records where we identified legal requirements had not been met. This included ensuring staff had provided a full employment history and that any gaps in employment were explored and accounted for.
- Where staff had a positive Disclosure and Barring Service check, the registered manager did not always complete a detailed risk assessment to establish if there were any risks associated with the employment of the applicant. DBS checks provide information including details about convictions and cautions held on the

Police National Computer. The information helps employers make safer recruitment decisions.
● Whilst we were told there was a dependency tool in place that helped the registered manager determine the staffing levels needed, this was not available to view as it was not stored at the care home. The deputy manager told us the dependency tool had not been used or updated in over a year which meant it was not used in determining that the staffing levels were safe.
● A member of staff had been recruited by the provider without checks of their skills and competence to deliver the job role. This meant neither the provider nor registered manager could be assured of their skills to perform in their job role safely.
● We brought these concerns to the attention of the registered manager who acted to address this; however, these risks and concerns had not been identified by the registered manager or provider and were only identified as a result of our visit.

Unsafe recruitment practices which put people at risk of harm was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Through our observations and speaking with people who lived at the care home, their relatives and staff, we found there were enough staff available to meet people's needs in a timely way. One person said, "If you want help you just press the bell, and someone will come." Another person's relative told us, "There doesn't seem to be a high turnover of staff and that's a sign of a good care home."

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were infection control issues which had not been identified and mitigated within the care home.
● There were several bathrooms in use. Across all of the bathrooms and toilets we found equipment rusty, such as handrails and toilet seat raisers which meant they could not be cleaned appropriately. We also found damaged flooring which meant it could harbour bacteria and would not be able to be cleaned effectively.
● Some baths and taps were affected by limescale and in need of de-scaling presenting a risk of bacteria harbouring.
● The tile grout at the back of the laundry room sink was mouldy and the walls had paint peeling from them. This meant these areas could not be effectively cleaned.
● We found black mould on pipework inside the sluice room. Mould can produce allergens irritants and, sometimes, toxic substances and may, therefore, have caused people or staff harm.

The provider failed to assess the risk of, and preventing, detecting and controlling the spread of, infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed housekeeping staff and care staff cleaning frequently touched points such as handles and switches on a frequent basis.
● People were able to receive visitors without any restrictions as the registered manager and staff team were following government guidance. We observed people to be enjoying visits from family members during our visit.

Using medicines safely
● People were at risk because people's medicines were not always managed safely.
● We found multiple discrepancies in records against quantities of medicines available at the care home.

This suggested some people may have not received their medicines or had received incorrect doses of them. The registered manager was unable to account for where the missing medicines were.

● Following our inspection visit the registered manager told us they had investigated the concerns about unaccounted medicines and had established an error with the electronic medicines administration records where the system inventory held additional stock than the amount actually held. Whilst the stock levels were correct, this error had not been independently picked up.

● Medicines were securely stored in designated medicine cabinets. Staff administering medicines had completed relevant training and had been assessed by the registered manager as competent to do so.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe at the service. One person commented, "Yes, I do [feel safe living here]. I'm quite relaxed, I feel secure and I am being looked after."

● Systems were not always effective to safeguard people from abuse and harm as there were risks that had not been assessed and mitigated against.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the care home was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was ineffective monitoring of the environment and a potential impact of this on people's safety. Neither the provider nor the registered manager were proactive in the management of, and reduction of risk.

- Areas of risk were not consistently being assessed and managed. A lack of effective environmental audits meant the safety and infection control concerns we found in the home had not been identified by the registered manager or provider independently.
- Quality assurance systems were not robust enough in identifying issues, such as the safe recruitment of staff, medicines stock check errors and environmental risks such as equipment safety checks not being completed. The provider could not be assured risks to people were mitigated because these checks were not being carried out effectively.
- The registered manager told us staffing was based on a dependency assessment of people's needs. However, they failed to ensure that the data they based their dependency tool was accurate.
- The governance systems in place were not always effective in monitoring and mitigating risks to people. A lack of provider oversight has meant that the quality and effectiveness of the management oversight were not reviewed.

Effective quality assurance systems were not in place to mitigate risk of potential harm to people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a positive, kind and caring culture within the care home. Relatives described the atmosphere as, "It's quite a happy place. People who work here seem happy and [people] seem happy." and, "Very good, happy, friendly and well-motivated. They [care staff] always get [people] involved." All relatives spoken with told us they would recommend the service.
- We observed staff interacting with people and found they were kind and caring and offered people choices.
- Staff and relatives spoke positively about the registered manager. All staff we spoke with told us they enjoyed their job roles and felt well supported.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was supported by a deputy manager and team of senior care workers. The management team understood their duty of candour and legal responsibilities.

● The registered manager understood the duty of candour. People and relatives were informed if anything went wrong and were kept fully up to date. One relative told us, "[Family member] has had a couple of falls and they have actioned it perfectly. They are transparent, definitely yes. They rang me straight away."

● Staff were clear on their roles and there was a clear line of delegation. Staff knew who to report their concerns to should they have had any. One member of staff described that they were, "Confident to raise concerns with the registered manager or deputy in the knowledge that they would act."

● The registered manager was responsive to any feedback during the inspection and keen to ensure compliance and safety.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had systems in place to gain people's views and opinions about the quality of the service provided.

● People and their relatives knew how to provide feedback about their experiences of care and the service. One person told us, "I've had one [survey] about the food recently."

● The registered manager told us regular feedback was sought and responses compiled to see if any action was required.

Working in partnership with others

● The staff team worked closely with other health care professionals and referrals were made in an appropriate and timely manner.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the systems in place to monitor and improve the quality of the service were effective.

The enforcement action we took:

We issued the provider with a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not always protected by robust recruitment procedures.

The enforcement action we took:

We issued the provider with a Warning Notice