Redhouse Nursing Home (UK) Limited

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Inspection report

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Date of inspection visit:
14 September 2017

Date of publication:
02 February 2018

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

We carried out this unannounced focused inspection on 14 September 2017. Redhouse Nursing Home provides accommodation for up to 34 people who may have nursing needs. At the time of our inspection there were 30 people living at the home.

We undertook a comprehensive inspection of this home in May 2017 where we rated the provider as "requires improvement" in all of the five key questions we inspected. At our inspection in May 2017 we found the registered provider had breached two of the legal requirements. This was because we could not be sure risks to people's health and safety were managed appropriately. The governance system operated by the registered provider was not effective in identifying and correcting issues raised by ourselves during the inspection. We issued two warning notices relating to each of the above two breaches. Warning notices are one of our enforcement powers. This inspection was planned and undertaken to look at the key questions of safe and well led, to check if the action required in the warning notices we issued had been taken. This report only covers our findings in relation to those requirements. You can read the full report from our last comprehensive inspection by selecting the "all reports "link for Redhouse Nursing Home on our website at www.cqc.org.uk.

At the time of our inspection the home had a registered manager. A 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 2008 and associated Regulations about how the service is run. However, the registered manager informed us during this inspection they had resigned from their post and would be leaving the service. Since our inspection the registered manager has de-registered with The Commission.

Although people told us they felt safe living at Redhouse, we found people were still not always protected from harm because risks to their health and safety were not always managed safely. People still did not always receive their medicines as prescribed.

We found the quality assurance system in place was still ineffective because the provider had relied solely on the registered manager and had no overview of the service which meant where concerns were highlighted the provider had failed to take action to protect people.

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 consistently safe.

Risks to people's health and safety were not being managed effectively which meant people were at risk of unsafe care.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider had no oversight of the governance system and had relied solely on the registered manager. The governance system in place was not effective which meant the provider was not ensuring the care people received was monitored and improved.

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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. At our previous inspection in May 2017 we found the registered provider had breached two of the legal regulations. We issued two warning notices relating to each of the above two breaches. Warning notices are one of our enforcement powers. This inspection was planned and undertaken to look at the key questions of safe and well led, to check if the action required in the warning notices we issued had been taken. This inspection took place on 14 September 2017 and was unannounced.

The team consisted of one inspector and a specialist advisor. The specialist advisor was a qualified nurse who had experience of medicine management and working with older people and people living with dementia.

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 sought feedback from the commissioners of people's care to find out their views on the quality of the service. We also contacted 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 three people who used the service. We spoke with the registered manager, the deputy manager and three members of staff and a visiting health professional. We carried out our observations during the day to help us understand how risks to people's health and safety were managed. We looked at three people's care records and medicine records for five people. We looked at records relating to how the service was run such as medicine audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2017 we rated the provider as requires improvement in safe. This was because risks to people's health and safety were not being managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection we issued a warning notice to the provider which gave them a date in which they were required to make the necessary improvements to ensure people got safe care. At this inspection we found some improvements had been made in the management of people's risks but these were not sufficient to meet the requirements of the warning notice.

At our inspection in May 2017 we found where one person was at risk of choking and had thickened fluids to reduce this risk. Staff did not have consistent skills or knowledge to provide this person with safe care. We saw this person was given fluids which were not of the correct consistency which made them choke and go red in the face. At this inspection staff told us they had received further training regarding the management of people's choking risks and they now understood what quantity of thickener people required in their fluids to reduce their risk of choking. We saw the training staff had received was effective as we observed staff supported one person with their fluid which had been thickened to the correct consistency which meant their risk of choking was reduced. We spoke to staff about this person's needs and they explained to us their needs differed on a daily basis depending on their mood which meant they occasionally had more thickener. We looked at this person's care plan which did not reflect what staff had told us. The registered manager told us they would ask staff to ensure this was recorded in future.

At our inspection in May 2017 we found people were not always protected from the risk of harm because we found one person had sustained bruises from bed rails which were being used because they were not long enough to protect their legs from harm. At this inspection the registered manager told us they had replaced all the bedrails in people's rooms who required their use to keep them safe. We saw this improvement had been implemented which meant people were now protected from the risk of injury from unsafe equipment.

At our last inspection we found people were at risk of unsafe care because the systems in place to manage people's medicines were not effective at ensuring people always received their medicine as prescribed. For example, we found one person had not received their medicine to manage their blood sugars in line with the guidance available to staff. At this inspection the registered manager told us they had changed the morning medicine routine to ensure people who required medicine to manage their blood sugar levels were prioritised. Staff explained to us how they managed this type of medicine and what they needed to check prior to administering this medicine. We looked at one person's medicine record which confirmed they were receiving their medicine to manage their blood sugar as prescribed.

Although people told us they received their medicines on time, we found instances of people not having their medicine administered as prescribed. For example, we found one person who was prescribed medicine for Parkinson's disease. We saw they had gone without their medicine on two different occasions. This medicine is prescribed to a person to help them control the symptoms of the disease; which means not having the correct dose may have an impact on their health and well-being. The registered manager was not

able to offer us an explanation why this had occurred or what action had been taken to protect this person. Although there was no evidence to suggest anyone had been harmed by these errors the registered manager said they would review medicine management procedures following our inspection.

Although people told us they felt safe, we found risks to some people's health and safety were not being managed correctly. Staff told us how they cared for one person's sore skin. The registered manager told us this person had developed further wounds due to this person's skin rubbing against another area of their skin. We looked at this person's records and saw the guidance available for staff had not considered how to reduce this risk and as a result they had developed further sore skin whilst living at the service. This person's records demonstrated that their care was not consistent with how staff had told us they managed their condition. For example, staff told us this person required moving every four hours. Records confirmed what staff told us. However, we saw this person's care was not being completed in line with the guidance available to staff. The registered manager and deputy manager were not aware that guidance was not being followed and therefore were not able to explain why this person's risk was not being managed in line with their care plan. We found whilst the management of risks to some people's health and safety had improved sufficient progress had not been made to ensure people were consistently in receipt of safe care.

We looked at how the provider was managing people who were at risk of falling. We saw one person had been assessed at high risk of falls. We saw they had fallen on one occasion which had resulted in them being taken to hospital. We asked the registered manager, who told us they had not considered a falls mat to alert staff but would order one following this inspection. We asked what additional measures were in place to protect this person who was at high risk of falls in their room. The registered manager told us staff checked them regularly but this was not recorded in their care records so we could not be assured staff were monitoring this person's risk of falls safely. We looked at this person's care record and did not see what action the provider had taken to reduce this risk since their discharge from hospital.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Therefore the terms of the warning notice had not been met.

Requires Improvement

Is the service well-led?

Our findings

At our three previous inspections in July 2014, November 2015 and May 2017 we rated the provider as "requires improvement" under this key question. This was because the governance systems in place were not effective in identifying and resolving areas where our inspection highlighted improvements were required. The provider had failed to ensure these improvements had been implemented following each of these inspections.

Following our last inspection in May 2017 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the governance system operated by the provider had failed to identify concerns raised during our inspection and the continued lack of improvement in the service. We issued a warning notice due to the lack of improvement made by the provider in this area. A warning notice is one of our enforcement powers. The warning notice required the provider to take action to improve the quality of the governance system in operation. We found the required improvements had not been made and therefore the warning notice had not been met.

The registered manager operated a governance system which included medicine audits, audits of people's mattresses and infection control audits. We saw some of these audits were effective in monitoring and improving the care people received at the service. For example, we found new flooring had been fitted in some areas as a result of the infection control audits in place. However, the system was not effective at identifying when staff provided care to people when they had sore skin. The registered manager told us there were no audits in place to ensure the care people received when they had sore skin was in line with the guidance in their care plan. As a result of this omission we found one person had developed further sore skin. This meant the system in place did not ensure people were protected from the risks associated with having sore skin.

We found the governance system had highlighted where records evidenced people had not received their medicines on time. However, we found the registered manager had failed to take sufficient action to improve people's care. We saw the governance system included an audit of individual staff which highlighted where errors had been made when administering people's medicine. Although our previous inspection had highlighted appropriate action hadn't been taken by the registered manager when staff had made errors with people's medicine, we found that this had not improved at this inspection. For example, we found when gaps had highlighted people had gone without their medicine; the registered manager had failed to protect people by seeking further medical advice. We found where individual members of staff had made repeated errors in omitting to give people their medicine the registered manager had failed to take any further action with regards to their competence in administering people's medicine. We spoke to the registered manager about this. They told us they had looked more closely at measures with regards to one member of staff but had not commenced any action. We found although this person had completed further training the registered manager had failed to ensure they were competent by getting it marked by the training provider. We found agency staff used by the service had made errors in administering people's medicines. Whilst the systems in place had highlighted these errors and the registered manager had alerted the agency with regards to the errors; these staff did not have their competency to administer medicines

checked and had been allowed to return to the service. This meant the system in place had not protected people from the potential risks associated with not getting their medicines as prescribed.

We found an example of potential abuse which had not been escalated within the service by staff. We found documented evidence in one person's care record of potential abuse. We found the member of staff had not escalated this further to protect this person from any further abuse. The system in place did not ensure that staff had the correct knowledge and skills to understand potential abuse and how to report it. This meant people may be at risk of harm or potential abuse because staff did not have the skills to recognise or escalate any potential signs of abuse.

We asked the registered manager how they were supported by the provider. The registered manager told us the provider was not involved in the day to day running of the service and had no input into the governance system operated at Redhouse Nursing Home. We found the system in place relied solely on the registered manager and had not ensured people were in receipt of safe care. The provider and registered manager had failed to develop an effective quality assurance system. The system in place did not always identify risks to people and areas of improvement required in the service. We saw areas of concern with regards to the care people received and the registered manager and provider had failed to identify and improve the quality of the care people received.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. Therefore the terms of the warning notice had not been met.

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 12 HSCA RA Regulations 2014 Safe care and treatment You have failed to ensure care and treatment is provided in a safe way for service users and have failed to do all reasonably practicable to mitigate risks.

The enforcement action we took:

We issued a Notice Of Decision to impose positive conditions on the providers registration. The registered provider must identify any risks and omissions in care found by the audits and include what action has been taken (including timeframes) to address the risks. The audits should include oversight of the care and treatment service users have received in

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance You have failed to ensure care and treatment is provided in a safe way for service users and have failed to do all reasonably practicable to mitigate risks.

The enforcement action we took:

We issued a Notice Of Decision to impose positive conditions on the providers registration. A summary of evidence of what audits of the service have been undertaken by the provider. The registered provider must identify any risks and omissions in care found by the audits and include what action has been taken (including timeframes) to address the risks.