Denise Weir in Partnership with The Red House Nursing Home (Northants) Ltd.

The Red House Nursing Home

Inspection report

High cross
Syresham
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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

Overall summary

This unannounced inspection took place on 11 February 2015.

The Red House Nursing Home provides accommodation for people requiring personal care and nursing care. The service can accommodate up to 25 people. At the time of our inspection there were 19 people using the service. The service provides nursing care and many people are living with dementia.

There was a registered manager in post. However, they were absent from their post at the time of the inspection. The provider had appointed an interim manager to run

Summary of findings

the home in the registered manager's absence. 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.

At the last inspection on the 9 September 2014, we asked the provider to make improvements to the care and welfare of people who used the service and this has been completed.

There were not enough staff to provide people with social interaction.

There were systems in place to manage people's medicines in a safe way.

People received an assessment of risks relating to their care. However, the provider did not manage specific risks to people's health and safety.

People were safeguarded from the risk of abuse. There were clear lines of reporting safeguarding concerns to appropriate agencies and staff were knowledgeable about safeguarding adults.

People received food that met their dietary needs and food choices were available.

The interim manager was not fully aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The interim manager had not made applications to the local authority when people were at risk of having their liberty restricted.

People received support to maintain their health and wellbeing and people's care was regularly reviewed to ensure it was effective.

People did not always experience care that maintained their need for privacy and dignity.

People were not supported to undertake a range of social activities and pastimes.

The provider had a complaints system; however complaints were not always recorded.

People were asked for their feedback about the service; however improvements were not always made.

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.

The staff struggled to provide a good service to people and had little time to spend interacting with people. There was a recruitment process in place which included obtaining references from previous employers and making sure staff had a Department of Barring Services (DBS) check. A DBS check helps employers make safe recruitment decisions. Risks to people's health and safety were assessed; however, some specific risks had not been managed. People told us they felt safe at the home and there were safeguarding procedures in place to protect people from the risk of abuse. There were good systems to manage people's medicines in a safe way.

Requires Improvement

Is the service effective?
The service was not always effective

There were systems in place to assess people's decision making abilities, however assessments had not been fully or accurately completed. The interim manager did not always understand their responsibilities when people needed a deprivation of liberty safeguard (DoLS). There was a system of staff training in place and we observed that staff provided care that met people's needs. The food served was of a good standard and staff monitored people who were at risk of not eating and drinking enough. People were supported to receive care that met their health and wellbeing needs.

Requires Improvement

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

People did not always receive care that met their need for privacy and dignity. We saw that staff had a kind and caring approach to people; however the arrangements for supporting people with dementia to make choices needed improvement.

Requires Improvement

Is the service responsive?
The service was not always responsive

People were not supported to undertake a range of social activities, hobbies or interests. We found that people did receive support to maintain their health and wellbeing and staff worked well with health professionals involved in people's care. People's relatives told us that complaints were not always dealt with appropriately and there was no information displayed about how people could make complaints to the provider.

Requires Improvement

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

Requires Improvement

Summary of findings

The systems in place to manage the home were disorganised. The interim manager found it difficult to find information that we requested about the safety of the premises. There were some quality improvement systems in place, however the provider was slow to make improvements to the home and there were limited systems in place for people and their relatives to feedback about the service received.

The Red House 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 unannounced inspection took place on 11 February 2015 and was carried out by two inspectors. The inspection team was supported by an Expert-by-Experience (Ex-by-Ex). An Ex-by-Ex is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor had specialist knowledge of providing dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the service including statutory notifications. A notification is important information about events which the provider is required to send us by law. We also spoke to health and social care professionals and service commissioners. They provided us with information about recent monitoring visits to the service including the outcomes of safeguarding investigations.

During this inspection we spoke to the interim manager and six care workers. We spoke with four people who were using the service and two relatives. We undertook general observations in communal areas and during mealtimes. We used the 'Short Observational Framework for Inspection' (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of five people who used the service and six staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

We asked registered manager to send us information about the safety and suitability of the service. The interim manager sent us this information within the agreed specified time.

Requires Improvement

Is the service safe?

Our findings

The staffing levels had recently been reduced to reflect the reduction in people living at the home. However, staffing levels were calculated based upon the ratio of people to staff rather than on people's needs. While people told us there were enough staff to meet their needs; we saw staff were rushed in their approach particularly during the busy times of the day. For example, staff had little time to interact and spend time talking to people and were hurried in serving and assisting people with their lunch.

The staff reflected the need for more staff to provide an enhanced level of care. One staff said "To be honest, we need another carer and we often have to wait for someone to assist us with the hoist or with assisting residents whilst in their beds". Another staff said "'It is hard to get all the work done and sometimes there needs to be one more member of staff for the early morning as many ladies do not want a male carer and so there can be delay". The staff rota showed that male and female staff were planned to work each day, however several residents required female care staff. The interim manager was aware of this situation and had recruited more staff to address these needs. We also saw that nursing staff assisted with people's care at busy times of the day. We also observed one person requiring one to one care received this at all times.

Risk assessments were undertaken; however they did not always identify significant risks to people's health and safety. For example, there was no general risk assessment in place which identified two areas of slopped flooring in the corridor and main living area of the home. We observed that people at risk of having a fall frequently accessed these areas and this had not been considered in risk assessing the premises. The interim manager told us they had identified this and had plans to improve this area of the home. We saw a variety of risk assessments had been undertaken to reduce the risk of unsafe care. This included the risk of developing pressure ulceration, risk of losing weight and risks associated with using bed safety rails.

People told us they felt safe living at the home. However, we found that care staff did not always understand safeguarding procedures. For example, while staff knew how to recognise different types of abuse, they were not always clear on the procedure for reporting safeguarding concerns at the home. The nursing staff told us that care staff did raise any concerns about people's care with them. One staff said "If carers are concerned about anything or think there is something untoward they come and get me straight away". We saw that when safeguarding concerns had been identified, then appropriate referrals and notifications had been made to agencies such as the Local Authority and the Care Quality Commission (CQC). We saw that safeguarding investigations had been taken seriously by the interim manager who had investigated any safeguarding concerns appropriately.

People told the staff were nice and friendly. One person said "Yes, the staff are all nice". Another person nodded and agreed that staff were of good character and treated them well. We saw the provider had recruitment processes in place to ensure staff were of suitable character and had the skills necessary for the job role. Staff confirmed that they had received an interview and checks were made to check their suitability to work at the home. The provider had undertaken checks such as a Disclosure and Barring Service check (DBS). This check helps employers make safer recruitment decisions and prevents unsuitable people from being employed. We also saw the provider had obtained employment and personal references to confirm the staff's suitability to work at the service.

There were systems in place to manage medicines safely; however people's feedback reflected the need to improve. One person said "The medicine comes at some time, when they're ready; the three doses can get squashed into a short time". Another person said "Generally, my medication comes on time". We saw that staff had made several improvements to the management of medicines such as improving medicine stock levels. We also saw that safe systems were in place to obtain, store, administer and dispose of people's medicines. While we saw that medication administration records (MAR) were in place, we found that there were occasional missed signatures, however, stock levels were accurate confirming that people had received their medicine. We found the staff were knowledgeable about people's medication needs and demonstrated competency when administering people's medicines.

Requires Improvement

Is the service effective?

Our findings

The arrangements for assessing people's capacity and in relation to the Deprivation of Liberty Safeguards (DoLS) needed improvement. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. People received an assessment of their capacity to make specific decisions about their care. However, we saw that assessments had not always been fully or accurately completed, making it difficult to see how people's capacity had been assessed. The interim manager was not fully aware of their responsibilities to make applications to the local authority where there might be a restriction to people's liberty. However, after the inspection visit they confirmed that all DoLS applications had been made.

There was a system of staff training which provided staff with a basic understanding of care. One new member of staff told us "I had an induction over a period of six weeks and this included training on how to use the hoist and sling". Another member of staff informed us they had received training on managing people's behaviours that challenged the service and we observed staff provided care in line with their training. The staff records confirmed that there was a system of training and development which included subjects such as the management of medicines, moving and handling and safeguarding of adults. Training had recently been improved from an electronic system to providing staff with more face to face and practical training courses. Staff received support to do their jobs and told us there was a system of staff supervision in place. One member of staff said "The manager is trying to provide good support and training". Other staff reflected on having regular opportunities for team meetings and one to one supervisions with their manager to discuss providing care for people and any identified training and development needs.

People received a choice of suitable food and drinks. One person said "There was homemade steak and kidney pie yesterday and it was really nice". Another person said "'they come round and ask what we want from the menu. We get a sandwich and salad at 4.30pm and there is soup later on". We observed that the meals served looked appetising and were well presented to people. The cook was knowledgeable about people's nutritional needs and explained how meals were fortified with butter and cream to provide additional nutritional support. They also told us "people have three fresh vegetables served with lunch and there are fresh fruits every day and homemade soup is served at supper time". There was a planned menu in place which showed that people had access to a varied and balanced diet with a range of foods to choose from.

Staff identified people who were at risk of not eating and drinking enough and monitored their progression. For example, we saw staff made repeated attempts to encourage people to eat and drink and we saw that when people did not eat their meals alternatives were offered such as rice pudding and nutritional drinks. We observed staff had encouraging words to prompt people to eat. For example one staff said "You need food for energy, please eat". We saw that when people were at risk of not eating and drinking enough the staff monitored their progression. This included monitoring how much food and drink people consumed each day and making referrals to the dietician where necessary.

People received appropriate support to access health and wellbeing services. For example, one person told us "Yes, I had to see my GP yesterday". Another person said "If I'm not well they call the doctor". Staff told us people had good access to health professionals involved in their care For example, one staff said "People see their GP regularly and if there are any concerns about their medications we ask for a review, we also make referrals to specialists such as the dermatologist and dietician and a GP visits the home on a Tuesday. We also found that staff regularly monitored people and used clinical observations such as blood pressure and temperature checks to monitor people's wellbeing. People's care records showed that staff recognised signs of ill health and took appropriate action such as contacting people's G.P's so that appropriate treatment was sought .

Requires Improvement

Is the service caring?

Our findings

People did not always receive care that met their need for privacy and dignity. We found that two people were sharing a bedroom and arrangements were not in place to protect their privacy. The people both needed personal care to be given while in bed. We observed that there were no privacy screens or other measures taken to improve the arrangements for private care and staff told us it was a challenge to provide care discreetly. While the interim manager told this was an interim measure; this approach was not conducive to a caring environment where people felt valued and respected. We observed that staff treated people with respect and asked their permission before care was given. We saw that staff knocked on people's doors before entering their rooms and told us they promoted people's dignity by encouraging people to be independent and where possible to care for themselves.

People told us the staff had a kind and caring approach; however improvements were needed to preserve people's individuality and identity. We observed staff often referred to people as "My love" and "darling" instead of using their preferred name. We also found that people's bedrooms doors only displayed the number of their bedroom. There was no personalisation of people's bedroom doors such as the person's name or a photograph, or a familiar picture displayed. This made it difficult for people living with dementia to identify their own room. In general, we observed that staff had a good relationship with people living at the home and treated people with kindness and respect.

The arrangements to support people living with dementia to make choices needed some improvement. For example one relative also said "I would like the staff to give [person's name] more choice about having a bath or a shower; I think they would prefer a bath but always seem to have a shower. [Person's name] does not like showers and the staff find it difficult to encourage them in". We saw that people were offered plenty of choices throughout the day such as a choice of meal, drinks and snacks, however, there was a lack of focus in providing visual choices to enable people living with dementia to make decisions. For example, we saw one member of staff came into the living room with a clip board to ask people their choice of meal. However, we observed some people living with dementia struggled with making their choice. We saw that generally staff did not use visual aids such as showing people a choice of two meals or using pictures to support people with making their choices.

Requires Improvement

Is the service responsive?

Our findings

People told us there was a lack of social activities and access to the local community. One person said "We don't get out much, and don't do much, but we did play scrabble at Christmas time". Another person said "we do something every other Wednesday. The nurse sometimes does a quiz or they put a DVD on". A relative's also told us "there is nothing to do here, there are no activities". We saw that an activities board was clearly displayed for people with information about a planned range of activities. However, people told us the activities did not happen in practice and we saw that the advertised activity of 'dominoes' did not take place. We also observed that people generally spent their day watching the television or wandering around the home and there was a lack of scheduled activities or time spent assisting people to undertake individual pastimes. The interim manager told us that external visitors did come and provide entertainment for people, however there was little evidence of this happening in practice.

The home also had a lack of a stimulating environment found to be beneficial for people living with dementia and there were no tactile objects available for people to hold and feel or objects available to stimulate their memories. We observed that when staff played age appropriate music over the lunchtime, people responded really well and were moving to the music and singing along to some of the words. This provided an improved environment to people living at the home and people appeared stimulated and happy.

There was a system of care planning in place; however it was unclear how much people or relative's participated in care planning. One relative said "We try to give staff information about how [person's name] likes to be cared for but this is not always followed. Sometimes [person's name] hygiene is not good". One person said "I haven't seen my care plan but I could if I wanted to". Other people were unsure or unable to tell us how they were involved in the planning of their care. The interim manager told us that they were trying to improve the involvement of people and relative's in the planning of care and had plans in place for advanced end of life care planning to be undertaken with people and their families. We saw that that people did have a range of individualised care plans which contained information about their care needs. This included care plans for pressure care, nutritional well-being, falls prevention and behaviours that challenge the service. However, some care plans needed more information for staff to provide good care. For example while one person had a care plan in place for managing their behaviours that challenge which identified possible triggers to this behaviour there was a lack of evidence of how staff needed to manage the behaviour in practice.

The systems for managing people's complaints required improvement. For example, while we saw that information was displayed about how people could make a complaint this was relevant to the local NHS service and not about how complaint could be made to the provider. Relatives also told us that it was difficult to make a complaint about the service. One relative said "[person's name] clothes were filthy and I raised concerns with the manager". However they also told us their concerns were not fully resolved and were frustrated about this situation. The interim manager told us all complaints were logged centrally, fully investigated and resolved, however, we saw there had been no recorded complaints for over a year which made it difficult to see how people's complaints had been managed.

Requires Improvement

Is the service well-led?

Our findings

There was a lack of leadership at the service and the registered manager had been absent from their post for a considerable length of time. While we found that the interim manager had assumed the responsibility of managing the home, we saw they often provided care which reduced the time they had to manage the service. They had however, appointed a new clinical lead who was providing staff with more direction and leadership in providing care. The interim manager was in the process of improving the service by working towards full accreditation to the gold standards in end of life care. This included working as part of a team with other end of life services and improving pain relief for people. The interim manager was required to report on deaths at the service and show how improvements had been made to people's end of life care.

The systems in place to manage the home were not organised and there was a lack of focus in records keeping. For example, we requested several records to confirm the safety of the premises, including that of gas, electrical and water safety. The interim manager was unable to find this information and was unable to tell us when these important safety checks had been made. We asked for these important documents to be sent to us and while we received them within the specified time there was a lack of insight into the safety of the premises.

People and their relatives were asked for their feedback; however improvements were not fully made. For example, during the last year the interim manager had conducted a people's survey to find out how people would like the service to be improved. We saw that although people had stated overall satisfaction with the service, they had suggested improvements were needed to access to a range of activities. The interim manager told us that people had not suggested any specific activities and so they had been provided them with games such as scrabble, bingo and dominoes. However, we observed that people were unable to undertake these activities without the support of staff and this made it difficult to see how the service had improved in line people's needs.

There was an open culture at the home; however some staff needed to improve their understanding of whistleblowing procedures. For example, we found they had little knowledge of how they could whistle-blow to external agencies such as the Local Authority or Care Quality Commission (CQC). Whistle-blowing is when a member of staff suspects wrongdoing at work and makes a disclosure in the public interest. While staff were unsure of procedures in place we found that they were aware of their responsibilities in reporting incidents, accidents and any concerns to the nurse on charge. We saw that the interim manager did report safeguarding concerns to the local authority and Care Quality Commission. However, the provider failed to notify us about a lift that was not working properly in line with their regulatory duties. While we saw that the interim manager had made arrangements for people's care during this time, we were not informed that this limited them to running part of the service. After the inspection visit the interim manager confirmed that the lift was fully operational.

There was a regular system of audits and spot checks in place; however, when improvements were identified these did not always happen in practice. For example, staff told us that two sloping areas in the corridor and main lounge had been identified as an area of risk by the provider. However, nothing had been done to put additional measures in place to ensure people's safety. While, the interim manager confirmed their intentions to install additional safety features such as a light and a handrail they had been slow in implementing these improvements. We saw that a system of audits was in place and this included a medication, infection prevention control and food safety audit. We saw that the audits mainly identified that the service was being provided in line with the provider's standards.