

Bupa Care Homes (CFChomes) Limited

The Red House Residential and Nursing Home

Inspection report

Bury Road,
Ramsey,
PE26 1NA
Tel: 01487 898106
Website: www.bupa.co.uk

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Ratings

Is the service safe?

Requires improvement



Overall summary

We carried out an unannounced comprehensive inspection of this service on 9 February 2015. At this inspection we found that there was a breach of a legal requirement. This was because people were not protected against the risks associated with the unsafe administration of medication

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on 11 August 2015 to check that they had followed their plan and to confirm that they now met legal requirements. We also looked at the staffing levels provided in the service as we recently received concerns about these.

This report covers our findings in relation to both these topics.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'The Red House Residential and Nursing Home' on our website at www.cqc.org.uk

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 56 people living in the home when we inspected.

The home did not have a registered manager in post. The registered manager left their post in October 2014. 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 and associated Regulations about how the service is run.

Summary of findings

At our focused inspection on 11 August 2015, we found that the provider had followed their plan which they had told us would be completed by 31 May 2015 and legal requirements had been met.

Medication was stored correctly and records showed that people had received their medication as prescribed. Staff had received appropriate training for their role in medication management. People we spoke with told us they received their medication as prescribed and were asked if they required any pain relief.

Staff treated people in a way that they liked and there were sufficient numbers of staff to safely meet people's needs. People received care which maintained their health and well-being. People we spoke with were very happy with the care provided although they did say they occasionally had to wait because staff were busy.

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?

We found that action had been taken to improve the safety of the service.

People were having their medication administered by appropriately trained and competent staff.

This meant that the provider was now meeting legal requirements.

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

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' we would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement



The Red House Residential and Nursing Home

Detailed findings

Background to this inspection

We undertook a focused inspection of The Red House Residential and Nursing Home on 11 August 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 9 February 2015 had been made. We also had received some concerns regarding the staffing levels provided at the service. We carried out a check of the staffing levels during this inspection.

We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting legal requirements in relation to that question.

The inspection was undertaken by one inspector.

Before our inspection we reviewed the information we held about the service. This included the provider's action plan, which set out the action they would take to meet legal requirements.

During the inspection we spoke with seven people living at the service, the manager, three members of care staff, a nurse and the area manager. We observed staff providing care and support.

We looked at the medication administration records, observed medication being administered and looked at the staff rosters.

Is the service safe?

Our findings

At our comprehensive inspection of The Red House Residential and Nursing Home on 9 February 2015 we found that people were not protected against the risks associated with unsafe administration of medication.

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

At our focused inspection 11 August 2015, we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 13 described above.

During our inspection we observed some people being administered their medication. This was undertaken in a careful and sensitive way to ensure the person received the correct medication, and that they took this as required. A person told us, "I always take my tablets when they are brought to me. I know why I am having them to help me keep well"

Medication was administered by a nurse who told us they had completed training in medication administration and they had had their competence checked by the clinical service manager. Records showed that staff who administered medication had been assessed as being competent to undertake this task

We found that medication was stored securely and at the correct temperature. Appropriate arrangements were in place for the recording of medication. Protocols had been put in place for medication that was prescribed to be administered as required. Frequent checks were made on these records to help identify and resolve any discrepancies promptly. A medication administration error had recently occurred and prompt action had been taken. This resulted in a thorough investigation being undertaken and staff being provided with the outcome to ensure that lessons were learnt. This ensured that people remained as safe as possible.

Prior to this focussed inspection we had received concerns that the staffing levels at the home were not sufficient to meet people's needs.

During this inspection we found there were sufficient numbers of staff available to keep people safe and to ensure that they received the care they needed. Although most call bells were answered promptly we did note that one call bell had not been answered in a timely way. It was identified that the call bell had a fault. The manager immediately dealt with the issue and a replacement call bell was given to the person, with an apology for the delay. Regular audits on the call bell system were carried out by the maintenance person and issues were reported and action taken.

We observed that staff provided care to people when they required it. One person said: "When I pull my call bell, staff usually respond fairly quickly." Another person told us "staff are always around. I never hear bells ringing for a long time. If people need help, the staff are there for me and them".

The manager told us that they regularly reviewed the staffing levels to ensure that there were sufficient numbers of staff on duty. This ensured people's safety and wellbeing needs were being met.

Staff told us that, although they were very busy, they still had time to care and occasionally socialise with people. One staff member said: "Whilst I like working here we are always busy and more staff would be good. We do provide people with good care." Another staff member said: "I like working here, but when we all [care staff] attend the morning meeting it leaves only leaves the nurse, administrator (who is able to provide care if needed) and the housekeeping staff on the floor for emergencies". We spoke with the manager and they told us they were going to look at alternative ways for staff to receive the same information whilst not taking all care staff off the floor at the same time.