Red Homes Healthcare Grantham Limited

Red Court Care Community

Inspection report

12 St Edmunds Court
Grantham
Lincolnshire
NG31 8SA

Tel: 01476576811
Website: www.redhomes.com

Date of inspection visit:
01 February 2022
17 February 2022
22 February 2022

Date of publication:
19 October 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
Red Court Care Community provides accommodation, nursing and personal care for up to 49 people, some of whom may be living with dementia, physical disabilities and sensory impairments. People are accommodated across three separate wings. At the time of the inspection there were 46 people living at the service.

People's experience of using this service and what we found
People had risk assessments in place. However, risk assessments such as use of bed rails were not always followed, putting people at risk of entrapment.

Staff told us that they did not feel staffing levels were safe. We found the number of staff supporting people living with dementia to be inadequate. We found that there were delays in people receiving the care they needed.

Since the inspection the registered manager and deputy manager have been looking into making improvements to the staff rota and have said they will increase the staffing levels.

We found improvements were needed to safe medicine practices, such as storage and administration.

Although most staff were wearing PPE appropriately, we did find some staff did not always wear their mask in an effective manner.

Systems and processes to ensure visiting professionals were vaccinated from COVID-19 were neither robust nor effective. There have been several professionals who visited the service without anyone recording if they had seen their vaccination status.

The registered manager had delegated quality audits to heads of departments at the service. The registered manager had poor oversight of these audits. Issues within the service were not identified prior to the inspection. Issues included infection prevention control (IPC) and hygiene and cleanliness of the kitchen.

Not all incidents within the service were recorded effectively. Learning from events was not robust, themes and trends were not always identified. Learning was not always shared with the wider staff team. There was a high number of incidents involving people who were living with dementia. People living with dementia's care needs had increased, however it had not been assessed prior to the inspection that staffing levels needed to be increased accordingly.

People living at the service told us they felt safe and were cared for by kind and friendly staff.

Safe recruitment processes were in place such as disclosure and barring checks (DBS).

People at the service had access to a wide range of activities. We observed several people at the service engaging in activities during our visits.

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

Rating at last inspection
The last rating for this service was requires improvement (published 28 April 2021). The service remains rated as requires improvement. This service has been rated requires improvement for the last three consecutive inspections. Prior to this it was rated inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about infection control. We inspected and found there was a concern with staffing and the providers management and oversight of the service, so we widened the scope of the inspection to cover the key questions of safe and well led.

You can see what action we have asked the provider to take at the end of this full report.
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 Red Court Care Community on our website at www.cqc.org.uk.

Enforcement
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 safe care and treatment, deployment and staffing levels at the service, as well as oversight and management of the service.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

Red Court Care Community

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 included checking the provider was meeting COVID-19 vaccination requirements. 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
The inspection was carried out by three inspectors.

Service and service type

Red Court Care Community is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Red Court Care Community is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority.

We used all this information to plan our inspection.

During the inspection
We spoke with two people who use the service, seven relatives, 13 staff including carers, senior carers, laundry assistants, activities coordinator, nurses, deputy manager and the registered manager as well as a visiting professional.

We reviewed a range of records including nine peoples care records and multiple medicines records. We also looked at a variety of records relating to quality assurance and management of the service such as audits, policies and procedures and infection control documentation.

After the inspection
We continued to seek clarification from the provider to validate the evidence found.

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 required 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

● People had risk assessments in place in order to mitigate risk relating to their care needs. However, these risk assessments were not always followed.

● One person was assessed as high risk of falls. Risk assessment and care records stated bedrails should only be in place wall side as there was a risk of entrapment. Records stated a sensor mat should be in place to alert carers if the person was getting out of bed. On our evening inspection the mat was not plugged in. During the daytime when the person was in bed, we found the mat to be under the bed. Had the person got up from bed or fallen staff would not have been alerted.

● Another person's risk assessments and care records stated they needed bed rails to prevent them from falling out of bed. The risk assessment stated the person was at risk of entrapment if they would remove the bumpers from the bed rails. Care records stated staff were to check hourly to ensure bumpers in place. We found during inspection the person was in bed without any bumpers. The bumpers were out of reach and had not been put on the bed. There was a danger of the person becoming entrapped in the bed rails.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Several areas of the home required maintenance and refurbishment, leading to areas that could not be cleaned effectively in order to prevent the risk of infection. Some areas of the home were being redecorated during the inspection. However, some areas had not been identified prior to the inspection.

● Areas of the kitchen including cookers were unclean. The floor was damaged which meant it could not be easily cleaned. Seals in the fridge were damaged. Not all food stored in the kitchen had been dated when opened. During the evening inspection food had been found in the trolley used to transport food around the home at lunch, the food was not covered and had dried out. Inspectors asked staff to throw this food away.

● We found that not all staff were compliant in wearing masks to prevent the spread of infection.

● Foot pedal operated bins were not always available to staff when disposing of clinical waste. Soiled laundry was not always separated from unsoiled laundry despite the availability of colour coded laundry hoppers.

● Systems and processes to record if visiting professional had been double vaccinated against COVID-19 were not effective. Inspectors were not asked to show their vaccination status. Several visiting professionals including District nurses and maintenance people had visited without anyone recording if they had seen their vaccination status. From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an

exemption or there is an emergency.

Using medicines safely
● Medicines were not always stored and administered safely.
● We found discarded medicines in a communal living area. The service was undergoing redecoration during the inspection, the medicines were found in the lounge on the dementia wing. The lounge was not in use but was not locked.
● Stock control procedures for controlled drugs were not effective. There was an over stock of some controlled medicines. The deputy manager informed us that stock check should be done weekly. However due to pressures on staff time this was happening every two weeks.

The registered manager and the provider had failed to ensure people were protected from the risk of harm associated with their care. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities)

We identified a breach of Regulation 12(3), but the Government has announced its intention to change the legal requirement for vaccination in care homes.

● During the inspection the registered manager responded to the risk found. They ordered additional equipment and put additional checks in place to ensure people were not at risk of entrapment. They put new processes in place for recording when staff visitors and visiting professionals entered the service.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.

Staffing and recruitment
● The deployment and planning of staff rotas was not effective in meeting the needs of the people living at the service.
● Two staff during the day and one staff member at night were deployed to support 11 people living with dementia. When people required more than one staff member to support them with personal care other people were left unsupervised. We observed this to be unsafe both on the evening and daytime inspections. The registered manager said that staff should ask for support from other staff rather than leaving people unsupported.
● Staff told us they were unable to always meet the care needs of people at the service in a timely manner. One staff member said. "If someone is buzzing for the loo, they are having to wait longer. Sometimes they go in their pad which is not very pleasant for them.'
● During a resident's meeting one person had stated they felt uncomfortable about staff asking them to use their pads instead of being supported to use the toilet.
● Clinical and senior carers told us that they did not always have time to carry out duties designated to their role as they were helping meet the needs of people living at the service.

Staffing levels were not sufficient to meet the needs of the people using the service, placing them at risk of harm. This was a breach of regulation 18(1) (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment processes were in place including the use of Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer.

The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The management team at the home completed accidents, incidents and safeguarding analysis in order to learn from events, however the analysis needed to be more robust. Themes and trends were not highlighted. Lessons were not always shared with the wider staff team in order to prevent further incidents reoccurring in the future.
- Staff received training in how to keep vulnerable people safe from the risk of abuse and systems and processes were in place in order to make referrals to the local safeguarding team and to notify CQC when required.
- People and their relatives told us they felt safe living at the service.

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
● The registered manager's oversight of areas such as quality audits or management of staff allocation was not robust.
● The registered manager had delegated audits to heads of departments such as housekeeping, kitchen and maintenance. There were several areas of concern that were not identified by quality audits, such as the cleanliness of the service and storage of food at the service. The registered manager did not have robust oversight of these audits.
● Staff rotas were disorganised and did not always reflect the needs of the service. We were shown rotas where some days staffing levels were low and would be covered with agency. However, other days there were four or five additional staff rostered to work.
● Where peoples care needs had changed staffing levels had not increased to reflect the change needs. The registered manager said 18 months ago people living with dementia at the service had lower care needs whereas now most were funded for nursing care. However, this was not reflected in the dependency tool used to form decisions on staffing levels.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture at the home had been impacted by COVID-19, poor staffing levels and lack of management. Staff told us that morale at the service was low and that they were not able to care for people in the way they wanted due to staffing levels.
● We received feedback from staff regarding the registered manager. Staff said they did not feel they were supportive. Staff said they were more likely to go to the deputy manager with concerns and issues. Staff told us the deputy manager was more understanding than the registered manager.

Continuous learning and improving care
● The recording of accidents and incidents was not always effective. The lack of recording meant the service could not learn and improve from all incidents.
● We found incidents recorded in people's care records that were not recorded on the accident and incident log. Incidents that had been recorded were analysed by the deputy manager. However, this analysis did not cover themes and trends. There was not always thorough consideration made to how the incident could be prevented in the future.

The provider had failed to ensure that systems and processes were in place to drive quality and improvements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager has taken responsibility for quality audits at the service. These were shared with CQC and showed areas of concern had been identified.

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 provider and registered manager understood their responsibilities in relation to the duty of candour.
- The provider and registered manager notified the appropriate agencies, including CQC, of reportable incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service held regular residents meeting where people were able to give feedback about their care and the way in which the home is run.
- Staff said that they have regular staff meetings where they are able to express their views on the running of the home.
- We spoke with a community mental health nurse, who said that they service was good, warm and welcoming.

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 Risk assessments were not always observed by staff. Audits in relation to infection control were not effective in identifying issues found on inspection. Improvements needed to be made in relation to safe administration and storage of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient levels of staff to respond to people's needs. The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs

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 registered manager did not have effective oversight of quality audits at the service. Staff were not deployed effectively to meet the care needs of the people at the service. Accidents and incidence were not always recorded effectively nor were they effectively analysed in order to recognise themes and trends and learn lessons in order to improve the service.

The enforcement action we took:

Warning notice