Mr & Mrs P Sohanpaul

The Red House Nursing Home

Inspection report

Main Street
Maids Moreton
Buckingham
Buckinghamshire
MK18 1QL

Tel: 01280816916

Date of inspection visit:
26 May 2022

Date of publication:
07 July 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 Nursing Home provides accommodation and nursing care for up to 32 people. The building has accommodation spread across three floors. Twenty six people were living at the home at the time of our inspection.

People's experience of using this service and what we found
Practices at the home did not always keep people safe and ensure they were protected from avoidable harm. We found safeguarding referrals had not always been made to the local authority when required. We had not been notified of significant events which providers are required to inform us about. This included skin tears and a fractured thumb.

The home carried out checks when recruiting staff. Agency workers were used to cover gaps on the rotas, when necessary. The provider had not ensured it had obtained satisfactory evidence of recruitment and training from the agency, to make sure people were always cared for by workers with the right skills and experience.

People were not adequately safeguarded from the risks of fire. Records of fire drills were insufficient to demonstrate all staff had been effectively trained and would know what to do in the event of a fire or other emergency.

The provider had not ensured there was effective governance of the service, to make sure people received good standards of care. The nominated individual (representative for the provider) regularly visited the home but there were insufficient records of findings or suggestions for improving care practice.

Providers are required to act in an open and transparent way when things go wrong (duty of candour) and there are specific things they need to do in these circumstances. The registered manager was able to describe some actions taken, such as informing relatives or speaking with the person affected, but they were unable to demonstrate full compliance.

We have made recommendations regarding the risk assessment format for moving and handling, medicines practice and recording of accidents and incidents. We have made a further recommendation regarding the provider's monitoring of record keeping at the service.

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.

People were protected from the risks of infection as staff followed good hygiene practices. Staff worked in partnership with other agencies to promote people's health and well-being. Improvements had been made

in some areas to enhance people's quality of care.

Relatives spoke positively about the home. One relative told us "I will never be able to thank the staff for the happiness and kindness that they have brought into our lives during this difficult time. I would recommend The Red House to anyone in need of care." People we spoke with were complimentary of staff. One said "Staff are brilliant," another commented "They're very good to me."

Rating at last inspection
The last rating for this service was good (report published 6 November 2018). We also carried out a thematic inspection looking at infection prevention and control (report published 10 March 2022).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Red House Nursing Home 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 fire safety measures, safeguarding practice, ensuring sufficient recruitment checks have been carried out for temporary workers, notification of significant events, duty of candour and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

The Red House Nursing Home

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
The inspection was carried out by one inspector.

Service and service type
The Red House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and care as a single package under one contractual agreement dependent on their registration with us. 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 and held about the service. We sought feedback from the local authority and professionals who work with the service.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service. We had discussions with the registered manager and looked at a range of records. These included three care plans, three staff recruitment files and the staff training matrix. We checked a sample of quality assurance audits and records related to maintenance and upkeep of the premises. We viewed a range of health and safety records including accident and incident reports.

After the inspection
We requested additional evidence from the registered manager.
We contacted staff and relatives or advocates by email, to invite them to provide feedback. We received replies from four relatives or advocates and one member of staff.
We also contacted the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 good. At this inspection the rating has changed to 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.

Systems and processes to safeguard people from the risk of abuse
• Processes were not always followed when there were safeguarding concerns.
• Staff had received training on safeguarding and there were procedures to respond to abuse. However, we found incidents had not been reported to the local authority safeguarding team. This included injuries as a result of falls, some requiring hospital treatment, skin tears and a fractured thumb.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure systems and processes were established and operated effectively to investigate any allegation or evidence of abuse.

Assessing risk, safety monitoring and management
• Records of fire drills were insufficient to show staff were adequately rehearsed in what to do in the event of a fire. A record of a drill in May this year contained just one line and did not say which staff were present. The previous drill was conducted in July last year and consisted of two lines of writing, including who was present. In both cases there was no information about any issues identified, how long the drill took and areas for improvement. We could not be confident all staff working at the home were regularly involved in practice evacuations and would know what to do in the event of a fire.

This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not taken adequate measures to assess and mitigate the risks from fire.

At the previous inspection, we recommended the provider sought support from a reputable source about how to effectively monitor required actions arising from risk assessments. On this occasion, the registered manager and maintenance staff were able to provide us with information about works carried out although there was no overall action plan to refer to, which amalgamated all works required and charted progress in meeting these.

• The fire risk assessment for the home had been written in August 2020 and had a review date of August 2021. It had not been reviewed. The registered manager told us an external company would be visiting towards the end of June this year to address this.
• Equipment was serviced to make sure it was in safe working order. Gas appliances and the electrical installation were checked by contractors to ensure they were safe. The water system was tested to make sure people were protected from the risk of Legionella. The registered manager told us actions had been taken where issues were identified.

• Risk assessments had been completed as part of people's care plans. These included risks associated with falls, fractures, risk of malnutrition and likelihood of developing pressure damage.
• Moving and handling assessments had also been completed. This was a one page, quite basic format which did not take into account considerations such as the working environment (space, any restrictions on safe manoeuvring), the person's preferences and handling constraints such as pain, involuntary movements, brittle bones. There was a section for 'special needs' such as comprehension, vision and hearing but this had not been completed in the sample of assessments we checked.

We recommend the service seeks support from a reputable source to adapt and develop its moving and handling risk assessments.

• 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 service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment
• People were not always protected through safe recruitment practices.
• Agency workers were used to cover the home when necessary. We checked records provided by the agency to see what checks had been carried out. We found these were insufficient to demonstrate robust practices were used. For example, none of the records said an enhanced level of Disclosure and Barring Service (DBS) check had been carried out, or when. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• One record referred to a Criminal Records Bureau check. These were replaced by DBS checks in 2012 so it was not known how old the check was. One record did not include any information about a DBS check.
• Agency records listed training undertaken by its workers, but not when this was done. We could not be confident the home was using temporary workers who had been robustly recruited and had the necessary skills to meet people's needs.

This was a breach of regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not ensured people were cared for by temporary workers who had the necessary skills and had been recruited using effective processes.

• Staff personnel files for workers recruited by the service contained all required documents, such as written references, proof of identity and DBS checks.
• Staffing rotas were in place to ensure there was sufficient support for people.
• People spoke positively about staff. One person said "Staff are brilliant," another commented "They're very good to me."
• Feedback from relatives included "The staff are very approachable, welcoming, and warm…the staff

always make you feel welcome and that nothing is too much trouble."

Using medicines safely
• People's medicines were stored safely and administered by nursing staff.
• Records were kept of when medicines had been given. We noticed minor gaps to the record sheets alongside three times when tablets were due to be given. There was no system for checking that medicines records were completed before nurses went off duty.

We recommend the service introduces a system to ensure medicines records are completed from one shift to the next.

• The pharmacist conducted an advice visit in July 2021, looking at all aspects of medicines practice. The report was positive overall, with some recommendations, which the registered manager had attended to.

Learning lessons when things go wrong
• Records were kept of accidents and incidents at the service. These were mostly falls or suspected falls, where people were found on the floor.
• A monthly falls audit was carried out. We noticed this did not look at people's individual circumstances. For example, in March this year, eight falls were noted for eight different people. Information about circumstances of the fall was recorded on the same line and entered as one entry "dementia, unsteady on feet" for all eight people. Action taken was on one line for all residents and said "reassured, dressing applied." This did not provide assurance that individual needs were being examined, to identify any patterns, such as time of day or what the person may have been trying to do.

We recommend advice is obtained from a reputable source about good practice in examining trends for accidents and incidents, to prevent recurrence.

Preventing and controlling infection
• 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 using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date
• Arrangements were in place to ensure people could receive visitors safely and in line with recommended good practice.

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 good. At this inspection the rating has changed to 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
• Regulatory requirements were not being met at the service.
• We came across examples where we should have been notified of events, but this had not been done. This included skin tears, injuries following falls, a fractured thumb and the outcomes of applications to deprive people of their liberty. We had also not been informed when people's care was affected by the lift breaking down.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009, as the provider had not notified us of all events it was required to.

• We asked to look at records of monitoring and auditing, covering the previous 12 months. We could see audits had taken place of areas such as infection control practice, housekeeping, diabetes care and care plans. Monthly medicines audits were also carried out and the registered manager conducted night time visits.
• We asked what monitoring was undertaken by the nominated individual. The registered manager said they conducted a weekly walk round but there were no records of these.
• We contacted the nominated individual to ask what monitoring they had undertaken in the past 12 months. We were provided with a brief account of each visit that had taken place, with three or four typed lines per visit. The focus was mainly on maintenance issues and checking equipment.
• Monitoring and auditing systems did not identify the range of issues we found. This showed quality assurance systems were ineffective in identifying risks to people's health, safety and welfare.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to ensure systems or processes were in place to assess, monitor and improve the quality and safety of the service.

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
•There are specific things providers need to do to demonstrate duty of candour: telling the person (or, where appropriate, their advocate, carer or family) when something has gone wrong, apologise to the person (or, where appropriate, their advocate, carer or family) and offer an appropriate remedy or support to put matters right, if possible. There was no evidence to show the provider had done this following all relevant

incidents.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to fully demonstrate they acted in an open and transparent way and took appropriate actions to meet the duty of candour requirement.

At the previous inspection, we recommended the provider ensured there was senior managerial oversight to ensure records were accurate and up to date. During the inspection, we looked at a range of records. We have reported our findings about deficits we found under the Safe domain. These showed further work was needed to improve record keeping.

We recommend the provider regularly reviews record keeping as part of their monitoring role, to ensure improvements are made and sustained.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• People told us they received safe and effective care. A relative told us "The manager and lead nurse are always accessible and professional and I'm sure work very hard in their roles. I have had regular contact with (name of staff member) when I visit and she is very caring and professional…when my (family member) has been unwell they are quick to communicate, engage in the necessary health care and monitor closely using the correct procedures." They went on to add "I feel Red House have worked hard throughout the pandemic to make their residents safe and the management team has kept me informed of developments in this area."

• Another relative commented "My (family member) has been at The Red House since April this year and I am extremely happy and grateful to the staff for the care that (they) receive. (They) had a birthday and the staff made the day very special for (the family), they presented (family member) with a cake, candles and a card which we did not expect but their thoughtfulness made the occasion very special."

• A member of staff told us "One to one's (supervision meetings) happen on a regular basis, if I have any issues (I) can talk to (the) manager…(we) have a handover every day, where we are kept up to date with residents' health and medication reviews. It is a nice place to work, only issue I have is the lifts, as they break down too often."

Continuous learning and improving care; Working in partnership with others

• The registered manager told us about improvements which had been made These included participation in a national project to improve the well-being of people with dementia, improving garden facilities, purchasing sensory dolls and animal therapy visits.

• However, the findings of our inspection showed the quality of people's care had deteriorated from the previous inspection, as regulations were not always being met.

• We could see staff worked alongside health and social care professionals such as GPs and followed their advice.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of all events it was required to. Regulation 18

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 not taken adequate measures to assess and mitigate the risks from fire. Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13

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 systems or processes were in place to assess, monitor and

improve the quality and safety of the service.

Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured people were cared for by temporary workers who had the necessary skills and had been recruited using effective processes. Regulation 19

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to fully demonstrate they acted in an open and transparent way and took appropriate actions to meet the duty of candour requirement. Regulation 20