Red Homes Healthcare Grantham Limited

Red Court Care Community

Inspection report

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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 were accommodated on the ground floor across two units. At the time of the inspection there were 45 people living at the service.

People's experience of using this service and what we found
The risks to people's safety were not robustly assessed. The risk assessments did not contain enough information about people's needs. The systems and processes in place to safeguard people from neglect or poor care were not always used effectively by staff. Incidents and accidents were not always reported on.

The quality monitoring processes in place to review and analyse information both in people's care plans and incidents and accidents records were not effective, putting people at continued risk of harm.
There was not always a positive culture of person-centred care promoted at the service.

Staff undertook safe practices when administering medicines and there was enough staff to meet people's needs. There had been improvements to the environment and how this was monitored
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.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 6 April 2022) and there were breaches of regulation. A warning notice was issued to the provider and registered manager. At this inspection we found some improvements had been made and the provider was no longer in breach of one of these regulations. However, they have remained in breach of two regulations.

The last rating for this service was requires improvement (published 6 April 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full 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 Red Court Community 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 safe care and treatment, safeguarding people for abuse and improper treatment, as well as oversight and management of the service 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.

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 Care Act 2014.

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 service was inspected by two inspectors and an Expert by Experience undertook telephone calls to relatives during the inspection period. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
Red Court Community is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Red Court 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.

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 but they were absent from the service for the majority inspection period.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to 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 used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with nine members of staff including a support manager, two deputy managers, a nurse, a housekeeper and four members of care staff. Following our visit, we continued to review records and seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke by telephone with five relatives about their experience of the service.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 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.

The purpose of this inspection was to check if the provider and registered manager had met the requirements of the warning notice we previously served.

At our last inspection 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). The provider remains in breach of this inspection as there were still further improvements needed in the management of risk to people's care.

Assessing risk, safety monitoring and management

- The risks to people's safety were not robustly assessed. Risk assessments and care plans did not contain enough information about people's needs. When people's needs had changed, or there were changes to the environment, care plans were not updated in line with the changes. For example, there had been positive changes to the environment which had improved people's daily life. However, the associated risks with the changes had not been properly assessed and updated.
- Several people who were unable to manage their own safety had attempted to leave the building unsupervised, but this had not been risk assessed. For example, this was documented in a person's daily notes, but no incident records had been completed to enable clear monitoring of the person's behaviours.
- Although the deputy manager told us measures were in place to reduce the risks to people walking with purpose, we identified an area where a lack of assessment did put a person at risk of sustaining an unwitnessed fall. Following our visit, we were assured by the provider the deputy manager had addressed this concern.
- On the first day of our visit the personal emergency evacuation profiles (PEEP's), used to ensure people could be safely evacuated in an emergency such as a fire, were not up to date. Some people who required assistance to leave the build had changed rooms and this had not been reflected on their PEEP putting them at risk of not receiving the level of support they would require in an emergency. We ensured this was addressed by the deputy manager before we left the building.

Learning lessons when things go wrong

- There was not always effective learning from events at the service. We saw there were over 35 reported occasions of incidences of people exit seeking following the changes to the environment since our last inspection over a period of two month. However as stated above, these incidents were not appropriately documented, and lessons had not been learnt to mitigate risk. The lack of learning from these events put people at risk of unnecessary harm.

The above issues relating to the management of risk to people living at the service are a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● There had been some improvements at the service since our last inspection. The provider had worked with the management team to improve the environment for people. This had resulted in a calmer environment and supported people living with dementia.

Systems and processes to safeguard people from the risk of abuse
● The systems and processes in place to safeguard people from neglect or poor care were not always used effectively by staff. Incidents were not always recorded on the provider's incident reporting systems by staff resulting in the provider not having effective oversight of incidences and how they could work to reduce them.
● During the inspection period we were also made aware of an incident that should have been raised as a safeguarding concern . We needed to prompt the registered manager to ensure the local safeguarding team were also notified. This demonstrated the management team was not always aware of their responsibilities in managing safeguarding concerns and put people at risk of abuse.

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.

Using medicines safely
● At our last inspection medicines were not always stored and administered safely. At this inspection we found improvements had been made to this area of care.
● Staff undertook safe practices when administering medicines. Storage and management of controlled drugs was safely managed. People had protocols in place to ensure when they needed medicines on an as required basis these were provided when they needed them.

Staffing and recruitment
At the last inspection the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing levels were not sufficient to meet the needs of the people using the service, placing them at risk of harm. At this inspection we saw the changes the provider had made had improved the deployment of staff and impacted positively on the care people received. As a result, the provider is no longer in breach of this regulation.

● People told us staff came to support them when they needed them to. On the first day of our visit we saw the two deputy managers working to cover some short notice sickness and staff told us the management

team always tried to cover so there were enough staff to support people.
● There were safe recruitment processes in place to ensure people were supported by fit and proper staff. Staff references included those from the last employer, any gaps in employment were explained and the Disclosure and Barring Service (DBS) checks were undertaken. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People told us they were able to see their relatives on a regular basis. Relatives were happy with visiting arrangements. During our visit we saw the provider was following government guidelines. Relatives were able to visit in the communal area and in people's rooms.

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 as Requires Improvement. At this inspection the rating 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.

The purpose of this inspection was to check if the provider and registered manager had met the requirements of the warning notice we previously served.

At our last inspection the provider and registered manager 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. Although we found some improvements had been made, further improvements were needed to ensure compliance with the legal regulations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The management team did not always promote or ensure people's care was person centred or that staff promoted a positive culture when providing care for people. We observed mealtime experience in two areas over two days. Staff supporting people lacked organisation and were task orientated. On one occasion a staff member was handing out cutlery and napkins after people had been brought into the dining area. One person asked for knife with a better grip and was told by a member of staff, "they are all the same". There was no evidence of any mealtime audits to highlight short falls in the service people received.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Although improvements had been made by the provider in some quality audits related to the environment and people's medicines, there were still areas of quality monitoring which needed improvement to ensure people received high quality, safe care.
- Records of care and support were not always accurate or up to date. The changes to the environment that affected some people's care needs at the service had occurred approximately three months prior to this inspection. People's risk assessments and care plans had not been updated to show how best to safely support them as a result of the changes.
- There had also been a lack of robust oversight of the environment by the registered manager, and this impacted on the management of environmental risk to people. This had resulted in several adverse incidents which could have been avoided.
- Records showed when staff had recorded an incident in people's care records, they had not always reported these incidents on the provider's incident report system. This had not been highlighted on the care

plan quality audits undertaken by the registered manager and had resulted in staff not being challenged about their lack of record keeping. Furthermore, this meant incidents continued to occur without clear management oversight.

The provider failed to ensure systems were in place to ensure people received person-centred care and the quality of care improved. This was a continued breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulation 2014.

● Following our visit, we spoke with the provider who told us they were reviewing the quality monitoring processes to address the issues we had highlighted to them. The provider had already brought in support for the management team. This had resulted in the improvements cited above.
● The provider had recognised the concerns we found at our previous inspection and had made some positive changes to the service to support a person centred culture. The changes to the environment had been beneficial for those people living with dementia. The provider was also responsive to the areas where we had highlighted required further change.

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 management team understood their responsibilities in relation to the duty of candour. A relative told us the management team kept them informed of any changes to their family member's needs or when anything is wrong. They said, "(Staff) let me know straightaway."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Relatives told us they had completed surveys about the service. There were records of resident's meetings where people could air their views about the care they received.
● The feedback we received from staff about the registered manager was mixed. Staff told us they didn't always feel supported by the registered manager. However, staff told us they did feel able to go to the deputy manager if they had concerns. Staff told us they had received regular supervisions to support their practice.
● There was evidence from relatives and in people's care records of staff working with external healthcare professionals to support people's wellbeing.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks to people's safety were not properly assessed putting people at increased risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring processes in place were not robust. This had led to a lack of oversight of people's care needs.