Bupa Care Homes Limited

Summerville Care Home

Inspection report

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Tel: 01925265865

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16 June 2017
26 June 2017
27 June 2017

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This was the first rated inspection of this location which was registered in January 2017.

We undertook an urgent inspection on 16 June 2017 following serious concerns which were sent to the Commission. This unannounced inspection was undertaken at night and we checked on people's safety and welfare. Following this inspection the provider increased their staffing levels at night by one carer as a result of our findings. The provider also confirmed they were not accepting any new admissions.

On 26 and 27 June 2017 we undertook a further unannounced inspection.

Summerville Care Home is a nursing home with three units over two floors. There are lounges and a dining area and a lift for people to access both floors. There are gardens at the rear and separate outbuildings used for storage areas. There were 41 people living in the care home at the time of our inspection with a maximum occupancy of 45 beds.

This location requires a registered manager to be in post. A registered manager was in post at the time of our inspection. 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 this inspection, we found that the provider was in breach of regulations 9, 10, 11, 12, 13, 14, 15, 17 and 18 of the Health and Social Care Act Regulations 2014.

The service was not safe. We undertook a walk around of the care home and found it was not secure in some areas. The kitchens and corridor leading to the boiler and meter room were accessible to anyone entering the care home. The registered manager was made aware of this on 16 June 2017. We found this had not been remedied when we returned on 26 June 2017. The acting regional manager took action and ensured it was secured immediately.

There were not enough personal protective equipment (PPE) for staff to use and they were searching for items during delivering care for people. The registered manager agreed there should have been additional stock items within the care home for staff to access easily.

There were not enough staff on duty according to the dependency levels of the people needing care. Some people remained in bed as there were not enough staff to get people up, washed and dressed. The management confirmed their dependency tool had been incorrectly completed and therefore, the staffing levels were incorrect. Action was taken immediately and staffing including the number of qualified nurses on duty was increased.

Management of medicines was not always safe. We found prescribed thickeners were not being administered or stored safely.

Call bells were not being given to people who were able to use them to assist them to alert staff in an emergency or when they needed care. People's lights and televisions were being left on at night without their preferences being known to staff. People were making complaints regards noise levels at night including staff laughing and joking.

People were not always being protected from abuse or harm. The Commission are looking into specific incidents prior to making regulatory decisions about these incidents known to us.

People who were identified as being at high risk of falls were not being reviewed following each fall to mitigate the risks of a reoccurrence. Therefore, the provider was not taking reasonable steps to keep people safe.

Staff recruitment systems were safe and nurses' professional credentials were found to be active. Disclosure Barring Service (DBS) systems were in place with staff starting work when this check was completed.

People were complimentary about the food. We were concerned people's choices about what they wished to eat and drink were not always being adhered to.

Consent was not always being sought during care delivery. Deprivation of Liberty Safeguards (DoLS) applications were in place for people when appropriate and the service had a mental capacity framework in the care plans, however, staff were not always following it.

People we spoke were complimentary about the care staff. Staff we spoke with were concerned the care being delivered was task focused. We observed this on our inspection.

People's dignity was not always maintained due to the task led delivery of care and staff shortages with one person who had a toothbrush in a beaker of water which appeared to have been there for a significant number of days/weeks and an insect within it.

Activities were taking place within the care home but not tailored for people with dementia or for people within their bedrooms nursed in bed. There were no areas designed for people with dementia within the care home.

Complaints were being dealt with by the registered manager and residents' meetings were being held. The registered manager was following up on concerns raised by people.

Staff and people who lived there were complimentary about the registered manager. However, we did not always find the registered manager effective in identifying all the breaches that we found within our inspection. The registered manager regarded staffing levels to be accurate in meeting people's care needs however, we found the staffing levels were grossly under estimated to enable staff to meet people's care needs. This demonstrated a lack of effective leadership and governance within the care home.

You can see what action we told the provider to take at the back of the full version of the report. Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The staffing levels were not sufficient to meet the care needs of the people.

Medicines were not always managed safely.

People were not always provided with the means of alerting staff if they required urgent assistance.

People were not always being protected from abuse.

Is the service effective?

Requires Improvement

The service was not effective.

People were not receiving enough fluids to maintain good health. There was no fluid management policy in place for staff to follow.

Staff were not always following the principles of the mental capacity act 2005 legislation.

Healthcare professionals were being involved in people's care.

Is the service caring?

Inadequate

The service was not always caring.

Staff were providing task led care.

In view of the amount of tasks staff were undertaking they were unable to provide people with anything more than basic care.

People were not always being shown respect.

Advocacy services were available if people needed them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always receiving care when they needed it.

Activities were being provided but not tailored to the needs of people with dementia or who remained in their bedrooms at all times.

Care plans were not always being reviewed when there was a change.

Complaints were being dealt with by the registered manager.

Is the service well-led?

Inadequate

The service was not well led.

Audits of the care home had not identified the concerns found on this inspection.

The registered manager considered the staffing levels to be adequate to meet the needs of people when we found they were not.

Documentation was not always accurate and being completed either in advance or retrospectively. Care plans were chaotic.

People who lived there and the staff liked the registered manager and were complimentary about them.

Summerville Care 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.

The inspection took place on 16 May, 26 and 27 June 2017 and was unannounced.

The inspection team consisted of one inspection manager, three adult social care inspectors, a pharmacist, a specialist nurse advisor and an expert by experience.

An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We had not requested a PIR by the time of our inspection as it was registered on 31 January 2017. We reviewed statutory notifications received from the provider and reviewed these along with all other information we held about the service.

The methods used during this inspection included observing care and talking to people using the service, their relatives and friends or other visitors and interviewing staff. We also pathway tracked a number of people looking in detail, through review of their records, from when they were first admitted to the home to the present day to ascertain how their care had been assessed and managed. We also did a SOFI (Short Observational Framework for Inspection). This is used when there are a number of people who are unable to communicate to tell us how they feel about their care.

We reviewed 10 care plans and associated records and spoke with 12 people who lived there. Between all of the inspection team we spoke with 26 staff including the chef, maintenance staff and managers.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe. One person told us "The carers do alright for me I feel very safe". A second person said "I'm not frightened here it's very good". A third person told us "The staff are lovely with me I am settled here and I feel safe because I couldn't cope at home and my family helped me get here". A relative we spoke with told us "I think the staff are fantastic with {service user}I can't fault them {service user} had 2 chest infections recently and they are really on the ball in telling me and getting him medical help." Another relative said "The Manager is fantastic but there have been issues like his teeth left in bad water and I've got a picture of when I found him with a dirty vest with chocolate on it apparently it was a mars chocolate and they had 5 tablets hidden. I think {service users} hides them in their mouth."

We checked on our first day of inspection if people were safe. We found one person who was shouting out for help when we walked around the care home. We found the person had slid down the bed in what appeared to be an uncomfortable position. The person said "I'm in pain, it is down my hip and my leg. I don't know what has happened today." They said the staff hadn't come and that they didn't have the call bell. We asked if they usually had a call bell and they responded "No." We checked the person's care plan which stated '{service user} is able to use the call bell if they need assistance.' We found most people were not being provided with their call bells within reach. We raised this concern with the registered manager who took action and confirmed they would assess everyone's ability to use a call bell and ensure people had one to hand if they were able to use one. We were concerned regarding the practice of not providing people with call bells as people had been unable to alert staff when they needed help increasing the risk of harm for people if they were unwell and needed emergency assistance. We pressed a call bell in one person's room and we noted it took 12 minutes for a staff member to arrive. The person was in pain and needed their pain relief. We viewed the call bell print off and it did not reflect the amount of time taken for the staff member to respond to the call bell being pressed by the inspector.

We checked the incidents log and found incidents were being logged on a tracker. We were concerned from the information we received that staff were not always reporting incidents as they had occurred. The Commission are continuing to look into incidents of concern.

There was also a tracker for safeguarding concerns which had been logged with actions documented. We found there had been three substantiated incidents of abuse by staff documented on the tracker. These were of physical abuse, verbal abuse and financial abuse. The Commission also received camera footage from a family member evidencing an incident of verbal abuse which was also being investigated. We were therefore, concerned that although staff we spoke with were aware of the different types of abuse and knew what to do to report if they suspected abuse and staff had heard of whistleblowing the provider did not have sufficiently robust systems in place to ensure staff were following their duty of always protecting people from abuse.

We were informed by the registered manager the staff members were no longer working within the care home.

Staff were not always identifying and mitigating risks for people. The catheter plan for one person stated on the 6th of May 2017 'Use G Straps'. These were not utilised on the 11th of May 2017 and an injury was noted by the nurse changing the person's catheter.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not doing all that is reasonably practicable to mitigate any such risks.

During our walk around we found a beaker of gloopy thickened liquid in a beaker within reach on a bedside table in a person's bedroom. This posed a risk of the person choking if they attempted to drink it. We found there was no prescribed thickener for the person and it had run out. Therefore, we checked the system in place for managing prescribed thickeners in drinks and how the staff were administering them for people. These are usually prescribed by a person's general practitioner and so form part of the treatment required for them and should be accounted for in the same way as other medicines and given individually rather than on a communal basis. We found staff were using one person's prescribed thickener for all people in the home who were prescribed thickeners. This tub of thickener was seen on the drinks trolley in the lounge exposed with no lid so there was a potential risk of contamination. Staff told us they were using it for everyone who was prescribed thickener. Staff were not provided with written guidance about how many scoops of thickener were prescribed for each of the 13 people requiring it. Therefore, we were concerned staff would have difficulty recalling the amounts of thickener to be used for all 13 people. We found other people's drinks were not being thickened to an appropriate consistency therefore, increasing the risk of choking if thickened too much or of aspiration if not thickened enough. We found one tub of thickeners on one person's table within their reach posing a risk of them consuming it.

The system of administering and storing prescribed thickeners was therefore unsafe. We asked the registered manager to review their systems in place and to send a safeguarding alert to the Local Authority informing them of the 13 people who had been placed at risk of choking or aspiration. The registered manager took action immediately and sent us written guidelines they had put in place for staff and confirmed they had reviewed the system of storing thickeners.

During another day of our inspection we found one person had not been administered their PRN medicines – these are medicines that are prescribed to be given when needed. They were prescribed medication PRN to be administered to manage their secretions and the records we viewed confirmed they had not been receiving this. We observed the person nursed in bed and heard liquid pooling in the back of the person's throat. The nurse on duty was alerted to this who administered PRN medication however, we found the person had not been administered this for up to a month. The staff we spoke with about this agreed the PRN protocol wasn't adequate enough. They had also been admitted to hospital with breathing problems in May 2017. We asked the registered manager to send an alert to the safeguarding authority as the person had been placed at risk of harm as they had omitted to administer prescribed PRN medication.

This is a further beach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to unsafe management of prescribed medicines placing people at unnecessary risk of harm.

We observed staffing levels were not meeting the care needs of people at night time and following our night time inspection, the provider increased the staffing levels immediately to one additional carer at night. However, when we returned in the daytime we found further concerns related to staffing levels. We found three people were still in bed by the afternoon with staff rushing from one person to the next attempting to meet their care needs and ensure everyone was up and out of bed. There were 8 carers in the morning, dropping down to 7 in the afternoon and 4 carers at night with 2 registered nurses on shift. One staff

member who was a hostess administering drinks, had been requested to work in the kitchen. This meant the care staff were behind with getting people out of bed due to the time needed to ensure everyone had drinks. We undertook an analysis of dependency levels on the ground floor and found there were at least 13 people who required 2 staff members to assist them to get up, washed, dressed and hoisted out of bed in the mornings. One person we spoke with had been incontinent by the morning due to staff not returning to assist them to the toilet during the night.

This was brought to the attention of the registered manager, quality manager and regional manager. When we returned to the care home the following day the regional manager confirmed the staffing had been increased to 12 in the morning, 10 in the afternoon and 6 at night. Nursing staff was increased from 2 at all times to 3 in the mornings and a supernumerary nurse. The regional manager told us they had calculated the dependency tool was not accurate and people were not being provided with an accurate dependency score which reflected their care needs.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to there not being adequate staffing numbers to meet the care needs of people.

During a walk around of the care home on 16 June 2017 we checked the environment. We found the access into the kitchen, secluded corridor leading to the boiler room and gas/electric meters and sluice room was open to anyone within the care home. We pointed this out to the registered manager during the night time inspection on 16 June 2017. When we returned on 26 June 2017 we found the same areas of the care home were open and accessible. This posed a risk for people who were able to walk around the care home who were living with dementia. We were told by staff there were two people who would wander or "walk off". Therefore, there was a risk they could enter the kitchen where they had access to kitchen equipment and utensils such as sharp knives.

Despite the provider taking action to secure this area at our request they had not identified this risk themselves during walk arounds. We also identified with the registered manager present on the walk around that there was only one pack of wet wipes for all three units, which meant if staff were assisting a person to the toilet they had to leave the person to find the wet wipes. Staff told us they were having to leave people they were caring for to find the items they needed such as wipes and aprons. We walked to the store rooms where we found three boxes of wipes which had not been taken into the care home to be used. Therefore, stock items were not being replenished enough in the care home.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not ensuring the premises and equipment were secure and appropriately located for the purpose for which they are being used.

Recruitment practices were checked to ensure they were safe. We looked at two staff recruitment files and found they had not started work until their Disclosure and Barring check confirmed they had no convictions. These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We also checked all nurses PIN numbers were valid and in date. This is a check to ensure all qualified nurses were registered to practice with their professional body, the Nursing and Midwifery Council.

Requires Improvement

Is the service effective?

Our findings

We asked people if staff knew them well and if they knew how to provide care for them. One person told us "The regular staff are very good but there are a lot of agency and I don't think they are fully trained and they don't seem that bothered", a second person said "The regular staff are very good but I don't think the agency staff know what they are doing and not properly trained. One of the agency on nights rushed me a bit and I mentioned it to {registered manager} and the other staff and they have not been since". A relative told us "I think the staff are all trained as far as I can see and if they are not sure they go and ask the Nurses".

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 Act requires that, as far as possible, people make their own decisions and are supported 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found there was a mental capacity framework within the care plans which staff were completing. This confirmed if the person had any problems related to their mental capacity and if a best interest's decision was required. We found one person who was living with dementia and required a sensor alarm to reduce the risk of them falling, had a best interests decision in place for staff to place the sensor mat underneath the person's mattress.

One person was being provided with one to one support. The person's health conditions affected their ability to make some decisions. We observed a staff member standing or sitting next to the person for the duration of the inspection to reduce the risk of the person falling. However, we raised concern there was no best interests process in the records to demonstrate other least restrictive options were considered prior to deciding a staff member would be with the person at all times.

We found consent was not being routinely requested during day to day care delivery. For example, another person who had capacity to make the decision about what foods they ate had not been provided with the opportunity to provide consent or not to the foods provided. A staff member said "the family said it is ok for him to have English food", the person said "No my food must be {special diet} I am {faith} – the staff member said "{service user} has capacity issues." A relative told us their relative {service user} was having difficulty with their thickened drinks and it was reported to staff. We spoke with the person and confirmed they did not wish to have prescribed thickener as they did not like the taste/texture and had capacity to make this decision. Upon discussing this with the staff they were concerned the person should have the thickener in their drinks despite the person who had capacity saying they did not want it. We asked the registered manager to undertake a risk assessment and discuss the pros and cons of this with the person. The staff

were aware the person did not wish to have thickened drinks and was not drinking them but were not following the mental capacity framework and allowing them to consent or not.

This is a breach of regulation 11 of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014 as care and treatment of service users must only be provided with the consent of the relevant person and the provider must act in accordance with the MCA 2005.

The training record for staff was not visible for inspectors to review. We were informed by the registered manager it was held centrally at the provider's head office. We raised this with the quality manager who confirmed the provider no longer issued staff with certificates to confirm attendance at mandatory training. We requested the records from head office of what training each staff member had attended. This was provided for us to review. It confirmed 86.6% compliance with all mandatory training. Mandatory training included safeguarding, pressure ulcers, nutrition and hydration, mental capacity and DOLS, infection control, medication, challenging behaviour, bedside rails, basic food hygiene and moving and handling.

Staff told us they underwent an induction which also included agency staff. Another staff member told us they completed a five day induction. Staff were expected to undertake shadow shifts. Some staff told us they were receiving supervision but in a group not one to one supervision and other staff told us they have received a one to one supervision. Some staff said they had an annual appraisal.

We looked into the system of managing people's fluid intake and output for those people who were on fluid charts. We observed one person had dark urine, which is a sign of dehydration. They had numerous drinks on their table next to their bed. One was thickened, the other not thickened. We checked the person's care records at 12.55am. We found the person had been on a fluid balance chart but this had been stopped on 6 June 2017 with recordings of amounts of fluids now written on a sheet of paper but with no record of fluid output despite the person having a catheter. We found the total amount recorded in the sheets was 80 mls on 16 June 2017. As there was no fluid balance chart completed we did not know whether this meant 80 mls from 12 midnight or 80 mls for a 24 hour period. We spoke with the registered manager who confirmed they would take action and ensure a fluid balance chart was commenced. We also found the person's Malnutrition Universal Screening Tool (MUST) confirmed they had lost 10 percent of their body weight in a three month period. There was no weight recorded for the month of May 2017. The person had been referred to the dietician. We requested the GP visited the person to undertake a medical assessment due to our concerns that the person may have been dehydrated.

We looked at a further three fluid charts and found that some of the records were missing and where people had not received sufficient fluids, no corrective action was taken. We also found the staff were frequently recording "refused", "smacking the cup away", "trying to bite me", with no guidance for staff how to manage this.

We requested a fluid management policy to check what information was being provided for staff by the provider. The registered manager confirmed there was no fluid management policy in place. This meant staff were not being provided with enough information for them to know what would be an expected amount of fluids to be administered in 24 hours or when to identify if a person was showing signs of dehydration.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not meeting people's nutritional and hydration needs

We observed the lunchtime experience for people and observed it to be chaotic. A relative said "There's no

structure to the lunch time, it's chaotic". This resulted in confusion for staff and people not knowing when they would have their food. People were however, complimentary about the food. Another relative told us "The food is fantastic and when I come to visit my {service user} I sometimes have a full english breakfast or lunch with them. My {service user} has no complaints about the food and there is plenty of choice".

Healthcare professionals were being involved in people's care. We viewed entries in the care records to confirm staff were contacting the GP, dietician, speech and language therapist, urology and continuing Healthcare.

People living with dementia were not provided with memory boxes or memorabilia around the care home. This is good practice as this can help stimulate memories for people living with dementia. The environment did not contain any design with a particular focus on people with dementia, props or pictures/posters to provide points of interest for people whilst walking around. The garden was unkempt and was in need of attention. We were informed this was part of the care home's home improvement plan.

Inadequate

Is the service caring?

Our findings

People told us the staff were caring. One person told us "They do whatever I want and I have a shower every night and they treat me with respect." A second person said "They are very good with me I can have a laugh and a joke with the staff".

People were being encouraged to be as independent as possible. One person said "I can wash and shave myself but they help me with a shower every Wednesday and Sunday and if I want more I just ask them".

One staff member we spoke with told us "I love the residents, we have a good team here". Another staff member who spoke with us said "I would prefer to spend time with residents instead of running around". A third staff member said "I love the job, I love the people, we're not spending enough time with them, we don't get time to sit down and interact with people".

We found most staff we spoke with and observed as part of this inspection were caring in the way they spoke to people. However, the care delivery was task focused For example, there was a "pads round" at certain times so therefore staff were unable to provide people with more time than it took them to undertake a care task. This meant things were being overlooked for people. For example, one person's toothbrush was seen placed inside a beaker which contained what appeared to be a liquid which had been there for days/weeks and had an insect inside it. We were concerned this had not been identified by staff and also questioned whether the person had received oral care.

We observed another person who had stained clothing on and a third person had what appeared to be dried blood on their top sheet when lying in bed. Some rooms we looked in were untidy with numerous items scattered over the bedside table or in a pile in a corner of a room. There were strong odours in some areas of the care home. This was not dignified for people.

A fourth person had blood on their top garment whilst sitting having lunch. They said "I didn't notice that I was bleeding until you pointed it out. I had a nose bleed at breakfast I suppose if they helped me a little more with my meals they would have seen it quicker. When it was pointed out the Nurse came to clean me up". People's dignity was therefore, not being maintained due to staff shortages.

A fifth person was observed without any clothing on his lower half whilst lying in bed and his door wide open for people to see. People must never be left in undignified situations such as this.

People were also not always respected to make their own decisions and choices. One resident who enjoyed a particular type of food to follow their faith was being prevented from eating the food they enjoyed. The person explained they were not happy with eating English food and wanted a specific type of diet. The staff said "the family said it is ok for him to have English food", the person said "No my food must be {specific food} I am {religion/faith} - a registered nurse said "{service user} has capacity issues". The concerns were raised with the registered manager and we requested they spoke with the person to reassure them they are able to decide what foods they ate. The registered manager addressed this immediately and spoke with the

cook. We spoke with the cook who explained they had never been asked to provide a special diet for the person previously. We asked about the person who requested the special diet and the cook told us they had been asked by staff (upon the person's family's request) not to provide the person with another type of food so they did not serve it. We were concerned this practice of not allowing the person to make decisions they were able to make restricted their choices and was disrespectful. The provider must demonstrate the care delivery respects people's personal preferences, lifestyle, religion and care choices.

We viewed residents' meetings minutes dated April 2017and found it was documented that one person said "Yet again {resident} was being kept awake by fire doors banging, laughing and talking which was disturbing". There was evidence the registered manager was addressing this with staff however we were concerned staff would not have considered this to be basic practice to be quiet at night time to allow people to sleep.

We observed there were piles of incontinence pads scattered all across the care home in full view for any visitors to see. They were seen in corridors, on shelves and on people's tables and on floors throughout the care home. We raised concern that this was not dignified for people and they needed to be stored somewhere out of sight.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as service users were not treated with dignity and respect.

Advocacy services were available if people needed them. We found no one in the care home was requiring advocacy services at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

We asked people for their views. One person told us "there is a weekly activities planner and I get involved when there is something I like".

We checked if people were receiving enough activities to keep them occupied and stimulated. During the inspection we observed someone reading to people in a small lounge area and a film being provided for people to watch. One relative told us "They have 1 to 1 activities in a morning but in the afternoon there is reading, bingo, entertainers, board games and they have little prizes. They also go out on trips such as when they went on the Wizard narrow boat". We observed there were no activities or stimulation of people who were in their bedrooms. Staff were unable to spend time to talk with people and therefore, people with high nursing needs were not being provided with stimulation which was person centred to meet their needs. We viewed the weekly activities for people and found the morning activity seen on the chart stated "Daily sparkle chat in the lounge", "one to one's personal choice"., we did not see these activities taking place during our inspection.

We looked into whether people were receiving care according to what was set out in their care plan and if their care was being reviewed.

One person who we observed in the lounge had been sitting for a length of time. We checked their care plan which stated "Pressure Ulcer Prevention and Management" dated 27 June 2017 repositioned times were 2.30am, 6.15am, 9.10am and 14.50pm. This meant the person had not been repositioned for 5 hours and 40 minutes. The care plan stated the person needed repositioning every three hours.

We pathway tracked one person who had a history of falls. We found there was a falls risk assessment tool in place which was last updated on 4 June 2017 when we viewed it on 16 June 2017. We ascertained the person had been found on the floor in their bedroom near their bed on 6 June 2017 however, the falls risk assessment had not been updated following this incident. Furthermore the falls risk assessment was not accompanied with a falls care plan for staff to know what to do to reduce the risk of falls in the future. During the course of the inspection we viewed another incident of a fall from the person's bed had occurred on 19 June 2017. Therefore, the provider were not reviewing risks, updating risk assessments or assessing the risk adequately to provide staff with clear falls care plans to enable them to mitigate risks for people.

We found people were not always receiving care when they needed it and found some people were still in bed by 2pm in the afternoon. According to their care plan they were to be assisted out of bed in the morning.

During the night we found people's lights and televisions were left on by staff even when people were asleep. Staff seemed unaware of this and could not confirm who preferred their light to be left on and who preferred their lights to be switched off. Some people told us they found the television noise at night to be a problem. We asked the registered manager to check what preferences people had at night regarding their light and TV left on.

We undertook a SOFI in the lounge and observed one person repeatedly asking for the toilet and staff were ignoring them. Staff were rushing from one person to the next. When they responded to the person they said they no longer wished to go to the toilet. From our observations the person needed interaction with someone to talk to them when they needed reassurance. Staff were unable to provide this person centred care and sit and talk with them due to the number of care tasks they were attempting to complete. We observed one person who had one to one with a staff member with them at all times. We checked the person's care records and found there was no care plan for staff to know what to do when providing one to one support. There were a number of different agency staff who did not know the person and therefore the one to one time was not effective or person centred. Staff needed more guidance what was expected of them when providing one to one supervision.

People who lived at the care home, staff and relatives we spoke with as part of this inspection talked to us about the high turnover of staff and inconsistency of staff. One staff member told us "It would be better if they sent us the same staff from the agency". Consistency of staff to provide people with continuity and familiar faces provides reassurance for people. We found the lack of continuity was having an impact on people. For example, one person told us they were visited in their bedroom by two staff they had never met before to change the person's incontinence pad at 5am. The person said they didn't need a pad changing but needed assistance to use the toilet. The staff didn't return until 8am the next day by which time the person had been incontinent.

This is a breach of Regulation 9 of the Health and Social Care Act Regulations 2008 (Regulated Activities) Regulations 2014 as the provider was not providing care that was appropriate, met their needs and reflected their preferences

There was a complaints system in place and we viewed the file which contained numerous complaints which had been investigated by the registered manager. We found one complaint from a relative about one person's care. The complaint had been dealt with by the manager by contacting the relative and discussing the issues over the phone. As this was not regarded as a formal complaint there was no written response. There had been complaints about the call bells not working but this had resolved during our inspection. One person confirmed this and said "I have a buzzer by the bed and one near the toilet. About a month ago I pressed the buzzer because I wanted to get into bed and I waited almost an hour I can't stand so I need help. I mentioned this to the manager and there was a problem with the system and the engineer has been out and it's been better recently". Another person told us "{registered manager} is very approachable and I have complained to {registered manager} about the buzzer when I waited and that was sorted". Therefore, we were confident that when people raised complaints they were being dealt with appropriately.

Inadequate

Is the service well-led?

Our findings

We asked people for their views about the registered manager. Comments included, "{registered manager}, is very nice", "{registered manager} I think is lovely, comes round and has a chat with me to see if everything is okay" and "Overall I like {registered manager}."

We asked the staff about how the service was managed. Comments included, "You feel like you can speak out. {Registered Manager} is very caring of residents and staff, have everyone's best interests at heart", "I would talk to {registered manager}, they are very supportive" and "{registered manager} is firm but fair".

Staff confirmed they had completed a staff survey, the results of which were not available at the time of the inspection.

Prior to our inspection the local authority infection control awarded the service 96 % in relation to their infection control standards within the care home. We viewed the home quality assurance and health and safety committee meeting minutes dated 7 April 2017 which listed actions being taken by the registered manager. These included reminding staff to keep noise levels to a minimum at night due to two residents raising this at the residents meeting. This assured us people's concerns were being taken seriously by the registered manager.

During the inspection we found fluid balance charts in one person's room which were not belonging to the person. This was a breach of confidentiality. A fluid chart for the person was found however this did not contain an output and was minimally completed. There was no entry for breakfast. We found other concerns related to documentation. Care plans were chaotic and we found it difficult to find the information we needed during the inspection. Fluid balance charts were being completed in block format by the hostess during the day and were therefore, not a working document being completed by the staff who were administering the drinks. We therefore, placed no confidence in the charts being an accurate reflection of what people had to drink. This in addition to Bupa not implementing a fluid management policy for staff to follow added further to the risks for people's overall health due to poor management of people's fluid intake.

Records relating to thickeners were inconsistent and inaccurate. We reviewed the thickener records with the carer who had made up the drinks at 20.30 and they confirmed they had not filled in the entries, and this was usually done by the 'hostess' who worked on the day shift. On looking over other records, the records were usually recorded at set time periods within the day, and appeared in 'blocks' with the same handwriting. This meant an accurate and contemporaneous record was not maintained for each person using the service

Personal protective equipment stocks were low during our inspection however, stocks of other items such as incontinence pads were over stocked. We were therefore, concerned regarding the management of stock within the care home according to the needs of the staff and people needing care. This was visible when walking around the care home. Staff were searching for items they needed such as a net, aprons and wipes,

placing people at unnecessary risk at times leaving the person during a personal care task to search for items. This had not been identified or addressed through the governance systems in place or by the registered manager. We viewed audits were being completed within the care home such as quarterly health and safety audits. The audit we viewed dated 29 March 2017 did not include the assessment of personal protective equipment for staff. There were other checks undertaken as part of the audit such as slings used by staff, window restrictors, smoking facilities for staff but no checks of personal safety equipment.

The root cause and breaches found on the inspection were due to low staff numbers compared to the dependency needs of the people living at Summerville Care Home. We discussed this with the registered manager who told us they were unaware the staffing levels were not adequate to meet people's care needs. The dependency tool had been incorrectly completed by staff and signed off by the registered manager. We therefore, placed no confidence in the oversight and checks in place to ensure there were adequate staff levels. The registered manager told us they were undertaking walk arounds the care home and had not identified people's care needs were not being met. From the records we viewed we found the registered manager had completed a walk around audit of the building on 23 January 2017.

There was an acting regional manager in place of the regional manager who also had a responsibility to undertake checks at Summerville however, if not for this inspection the staffing levels would have remained at an inadequate level. Therefore, the governance systems and audits being undertaken were not identifying the concerns or root cause of the concerns we found during this inspection.

The unsafe system of administering and storing prescribed thickeners had not been identified through the walk around checks of the care home or through the governance systems in place.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have systems and processes in place to effectively ensure compliance with the regulations.

Providers are required to notify CQC of events or changes that affect the service or the people using it, for instance serious injuries or where the provider has made an application to deprive someone of their liberty. We found an allegation of abuse made by one person that had not been reported to the Commission.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 as the provider had failed to notify of an incident.

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 9 HSCA RA Regulations 2014 Person-centred care The care being provided was not always meeting the needs of the person taking into account their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not always upheld and people's choices were not always being respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Decision specific best interests documentation was not always clearly written to demonstrate the process was always being followed. One person who was able to make basic decisions such as the type of foods they preferred to eat was not being provided with the opportunity to make those decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We received information prior to our inspection to let us know people may not be protected from abuse. On this inspection we looked into

the safeguarding systems and found there had been three incidences of physical abuse, verbal abuse and financial abuse at the care home seen logged in the Safeguarding file. The care provider was therefore, not always protecting people from abuse.

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 The quality assurance systems and tools such as the provider's dependency tool did not identify the issues we found on inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Prescribed thickeners were not being stored or administered safely.

The enforcement action we took:

Urgent notice of decision to impose conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	There were areas of the care home which were accessible posing risks for people who wandered into the kitchens, corridor leading to an open boiler room.

The enforcement action we took:

Urgent notice of decision to impose a condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	People were not being supported when they needed their care due to low staffing numbers compared to the dependency needs of the people requiring care. People were remaining in bed for long periods and were not being supported to change their position as often as advised by the health care professionals to ensure they do not develop pressure areas.

The enforcement action we took:

Urgent notice of decision to impose a condition on the provider's registration