Summerfield Medical Limited

Summerfield Nursing Unit

Inspection report

58 Whittington Road
Cheltenham
Gloucestershire
GL51 6BL

Tel: 01242259260
Website: www.summerfieldnursing.co.uk

Date of inspection visit:
14 December 2015
15 December 2015

Date of publication:
15 February 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This full comprehensive inspection took place on 14 and 15 December 2015 and was unannounced.

Summerfield Nursing Unit provides accommodation and nursing care for up to 66 people who have nursing needs. At the time of our inspection there were 27 people living in the home across two floors. The home is a four floor, purpose built building. Each floor had a lounge, dining room and small kitchen. A cinema, library, hairdresser's salon and gardens were available to people who live in the home.

A new manager had recently been appointed to run the home and was in the process of applying to become the registered manager. 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 the last comprehensive inspection on 1 and 2 June 2015, this provider was placed into special measures by CQC. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do meet legal requirements in relation to breaches of regulations relating to people's consent to their support and care which was personalised and focused on them.

We undertook this full comprehensive inspection to check they had followed their plan and to confirm they now met legal requirements. This inspection found there were enough improvements to take the provider out of special measures. The provider now met their legal requirements but further improvement was required. We have made some recommendations which we will follow up at our next inspection.

A care management company previously commissioned by the provider and the new manager had made significant improvements to the standard of care that people received. They were working through a series of action plans with clear time frames to ensure the service progressed and improved. Effective systems and protocols were being developed and implemented to ensure people received appropriate care and support to meet their needs. The manager was aware of that the home had previously fallen below the required standards of care and was working with the provider and staff to ensure people received the care and support which they required. The manager recognised that whilst significant progress had been made in the care of people; there was still need for further improvement.

During the inspection we found the delivery of people's care had significantly improved, however there still remained some inconsistencies in some people's care and their records, although we found no negative impact on people as staff were knowledgeable about people's needs.

People benefited from a service where staff understood their responsibility to protect people. Risk assessments were in place to support people but the monitoring of people's risks was not consistently

recorded. Systems were in place to ensure people's medicines were ordered and given to them when required. People's records of their daily administration of their medicines were accurate. However further details were required for some medicines which would provide staff with additional guidance.

Staff recruitment procedures ensured that people were supported by sufficient numbers of staff to meet their basic care needs. However, there was no formal system in place to monitor people who were left unsupervised for periods. Social interaction and encouragement was not consistently carried out when staff supported people with their meals.

Some people did not engage in meaningful activities or social interaction throughout the day. However an activities coordinator had recently been employed to provide recreational and social activities to people. Some people's bedrooms had been personalised, though the home's environment did not support people with cognitive impairment or dementia. We have made a recommendation about improving the home's environment.

There were mixed comments about the meals and food provided. A cook had been employed to review the meals and provide a choice of homemade meals and snacks to be made on site.

People and their relatives were positive about the care and support they received from staff. Their individual needs were assessed, planned and recorded. Some people's care records did not always provide staff with adequate guidance; however staff were knowledgeable about people's needs. People were encouraged to make decisions about their care and support. Documentation of people who had been elected power of attorneys was limited and not always reflected in peoples' care records. Where people had a 'Do Not Attempt to Resuscitate' order in place, their records did not always follow guidelines. We have made a recommendation about the recording of these orders in line with national guidelines. When necessary, people had received additional support from other health care services if their needs had changed.

People were cared for by staff that had been trained and supported to carry out their role. Plans were in place to provide further support and training to staff. The manager had a good understanding of their role and how to manage the quality of the care provided to people. Plans were in place to improve the quality monitoring systems to check and address any shortfalls in the service. People and their relatives felt that any concerns raised were dealt with immediately.

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.

Improvements had been made to ensure people were safe and protected from harm and abuse. However the records of people's risk were not consistently recorded to reflect their needs.

An effective system was in place to order and manage people's medicines; however people's medicine administration records did not always document the support people received.

Staffing levels were sufficient to meet people's physical needs although no formal systems were in place to check people who were left unsupervised and unable to call for assistance.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements had been made to ensure staff knew their responsibility to gain people's consent before supporting them with their personal care. However, documentation for when people had requested others to act on their behalf was not always in place such as Do Not Resuscitate Orders.

The home's environment was not homely or did not help to orientate people to their bedroom or other facilities.

Where appropriate people were referred to health care professionals for additional support.

People received a balance diet. Plans were in place to provide homemade meals and snacks.

Staff were supported and trained to carry out their role.

Is the service caring?

Good

The service was caring.

People and their relatives praised the staff. Staff were kind and

compassionate to the people they cared for. They treated people individually and with dignity.

People were encouraged to remain independent and express their views.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements had been made to ensure people needs where assessed and recorded. A new care planning system was about to be implemented which the manager hoped would identify any gaps in people's care records.

There were limited opportunities for individual and recreational activities although this was being addressed by the new activities coordinator.

Staff responded promptly to people's individual concerns and understood their needs.

Is the service well-led?

Good

The service was well- led.

The manager had plans in place to address and review the shortfalls of the home.

People and their relatives spoke highly of the staff and the manager. Staff felt supported by the manager and deputy manager. The culture of the home was fair and open.

The quality and frequency of the monitoring checks of the service being delivered care was being reviewed and up dated.

Summerfield Nursing Unit

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.

This inspection took place on 14 and 15 December 2015 and was unannounced. The inspection was carried out by two inspectors 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.

Before the inspection we reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

We spent time walking around the home and observing how staff interacted with people. We spoke with five people, three relatives, six members of staff, the deputy manager and the manager. We looked at the care records of six people. We looked at three staff files including recruitment procedures, which included information on the training and development of all staff. We checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection, people's care, treatment and medicines were not being managed and delivered in line with their individual needs. During this inspection, we found that people were generally protected from abuse and avoidable harm, however, further improvement was still required to make the service safe.

People's medicines were mainly managed well. Effective systems were in place to ensure peoples' medicines were ordered, stored, administered and recorded to protect people from risks. People's medicine administration records (MAR) contained an up to date photograph of the person as well as details about their prescribed medicines and required dosage. People and their relatives told us people's medicines were administered on time and in a respectful manner. One relative said, "The medication did not used to be up to standard, but it's all sorted now".

However staff did not always record the support they had given to people around their prescribed medicines, although we found no negative impact on people. For example, people's MAR charts had been completed appropriately with no gaps in the recording of administration. However, if people had refused their medicines, the reasons for their refusal not been recorded other than a code on the chart which does not provide staff with sufficient information. There were no body maps for some people who received their medicines via a patch placed on the skin. This meant that staff were not aware of the previous location so they could rotate the position of the patch. Records of where people required physical checks such as their pulse being taken before receiving their medicines had not always been completed.

One person received their medicines covertly. A mental capacity assessment had been completed which indicated that this person did not have the capacity to consent to this method of administrating their medicines. However a best interest decision had been made with the GP but this had not been reviewed. There was no confirmation from the pharmacist that this would not affect the effectiveness of the medicine. The management of this person's medicines did not adhere to the home's medicines policy. This was raised with the deputy manager who told us they would speak with the pharmacist and GP to review this person's medicine.

Whilst audits had been carried out on the management of people's medicines, there was no consistency in the frequency and quality of the audit. For example, there was no monitoring of the stock balance of medicines held in the home which had led to an excessive amount of unrequired medicines being held in the home. The deputy manager told us plans were in place to improve the quality if the audits to identify any shortfalls in people's medicine records and also review the medicine stock levels in the home.

People's medicines were stored securely and storage temperatures were monitored and recorded daily. There were safe medicine administration processes and storage in place for people who required medicines which could be misused by others. Individual detailed protocols were in place for medicines prescribed to be given as necessary. For example, some medicines had been prescribed to people who may require the

occasional treatment for pain relief or constipation. The reasons why people had been given this type of medicines had been documented.

People were supported by adequate numbers of staff to meet their physical and support needs however there were no formal systems in place to monitor people who were left unsupervised for long periods of time without being checked. Whilst we saw staff undertaking random checks of people in the lounge and in their bedrooms, there was no clear structured monitoring system to check on unsupervised people who were unable to alert staff either in their bedrooms or in the communal areas. We received mixed comments from people about staff responses to call bells. Some people told us they sometimes had to wait for long periods before a staff member came to attend to them, whilst others felt the staff responded promptly. This was raised with the manager who said "I'm aware that we need to review how people are being checked as we are now encouraging people to spend their day in the communal areas so it requires the staff to be more alert in other areas of the home".

The staffing levels of the home had recently been reviewed by the manager. The deployment of staff ensured there was sufficient qualified and trained staff during a 24 hour period. The home had recruited appropriate numbers of staff and was now less dependent on agency staff. Where agency staff had been used, their personal profiles and training histories had been viewed by the manager to ensure they had the required skills to work in the home. The manager and deputy manager who were qualified nurses were also available to provide additional assistance and advice to staff when needed. The deputy manager had carried out spot checks during the night to ensure that people were suitability being cared for by adequate numbers of staff during the night.

The manager had requested that staff work on different units so they understood the individual needs of people throughout the home so they would be adequately skilled to work on different units if required. Staff confirmed this had been beneficial to them and they were learning about people and new skills from their colleagues.

People's risks had been identified and recorded. For example, assessments were in place for people who had limited mobility and were at risk of falling. The majority of people's risks were being monitored; however there were some inconsistencies in the recording of monitoring of their risks. For example, the monitoring of one person who had a history of losing weight had not been consistently recorded, although the latest recording stated they had now gained some weight.

However we saw records where people's well-being risks were appropriately recorded. For example, people's clinical observation such as blood pressure and pulse had been regularly checked and recorded. Records showed that people were sleeping on air mattresses which were checked regularly and were on the correct setting for their weight to protect their skin integrity.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. For example, one person had been provided with an alternative chair as they had fallen out of their wheelchair.

People had personal emergency and evacuation plans which detailed the support they required in the event of an emergency. The home held regular fire drills and weekly fire checks on the fire safety systems in the home. Further staff fire training was being arranged which would also cover the usage for the home's evacuation equipment. A colour coded system was to be implemented which would quickly identify the mobility levels of people and the support they would require.

The home generally followed safe recruitment practices. Records relating to the recruitment of staff showed the majority of relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identified if prospective staff had a criminal record or were barred from working with children or vulnerable people. However, clear records that the character of new staff had been explored or checked when limited information about people's employment backgrounds had been provided from previous employers were not in place. The manager was informed and action would be taken to remedy this where appropriate.

People were protected against the risks of potential abuse. Staff had the knowledge and confidence to recognise and report any safeguarding concerns. They had received up to date training on the types of abuse and where to report any allegations of abuse. The manager had been accredited to deliver safeguarding training. Discussions about the importance of the protection of people from harm and abuse were discussed at staff meetings. The manager said, "Our main priority is to keep our staff and keep our residents safe". The home's safeguarding and whistleblowing policy provided staff with guidance and the contact details of local and national organisations which could be contacted if they suspected abuse. Posters on the notice board provided people and their relatives with information about how to recognise and report signs of abuse.

People were protected by the prevention and control of infection processes in place. The home was clean and odour free. Relatives told us they were satisfied with the cleanliness of the home. Staff understood the importance of wearing disposable gloves, aprons and washing their hands appropriately.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, people's consent to their care and treatment was not sought in line with legislation and guidance. During this inspection we found improvements had been made in this area, however records of when relatives or other health care professionals had acted in people's best interest required further detail. The manager informed us that people's consent to their care was planned to be reviewed during the implementation of the new care records. They said, "We are moving to a different care planning system. When this happens we will be reviewing everyone's needs including their ability to consent to their care".

Consent to people's care and support was sought in line with legislation. Staff and the senior management team had a good understanding of Mental Capacity Act 2005 (MCA). 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 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. Staff encouraged or supported people to make their own decisions. For example, people were supported and prompted to make decisions about their day and choices of food and drinks being offered to them. If people were unable to make a decision, staff knew people well enough to remind them of their preferred choice. For example, staff reminded one person of their preferred choice of juice.

The rights of people who were unable to make important decisions about their health and well-being were protected. Records indicated that other significant people such as family members or GPs had been involved in helping people to make decisions about important parts of their care. The home held documentation which informed staff of who had been elected to have power of attorney on behalf of people, however this was not clearly documented on people's care records to inform staff of who may lawfully act on people's behalf. The position of being a person's power of attorney was discussed at residents and relatives meetings to ensure relatives understood their role when acting on people's behalf about decisions around their health and finances. The manager had referred people who lacked mental capacity and had no family representatives or power of attorney to the appropriate authorities when they had needed additional support with significant financial matters.

Some people had a 'Do not attempt resuscitate' order (DNAR) noted on their care records. There was limited evidence that the decision for people to have a DNAR in place had been discussed with them or significant others or the recordings of the legal framework required when families had agreed to sign the DNAR order. The DNARs of some people had not been reviewed when they moved into the home as recommended by national guidelines.

Where people needed to be deprived of their liberty, the manager had applied for authorisation to do this. People can only be deprived of their liberty to receive care and treatment when this 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). The manager was aware of her role to apply for the authorisation to restrict people who may be deemed being deprived or their liberty and freedom. Where

people had been restricted of their liberty, the manager had sought advice and made the relevant application for authorisation to do so.

People were supported to maintain a balanced diet; however they were not always supported to eat their meals in a social and enjoyable environment. During our lunch time, we observed staff supporting people with their meals in the dining room and lounge. One staff member said, "We encourage people to come to the dining room but it is their choice. It is good for them to socialise with others". Some staff interacted well with people, whilst other staff fed people with very little verbal communication or encouragement. People who were eating their meals in the lounge were not regularly checked or monitored. We were told that a further dining experience audit would be carried out by senior staff to capture people's views about their meals and the support they receive.

We received mixed comments about the meals provided. For example one person said, "I enjoy my food. It's all mashed up for me. It's quite nice". Whilst another person told us they had complained about the food and the lack of choice.

On the day of our inspection, a new cook had started in their role to oversee the kitchen and develop a menu which would meet the nutritional needs and preferences of people. Currently people received a choice of pre-made meals at lunch time which were heated up. The new cook explained they had been told to initially provide homemade puddings and a selection of sandwiches and cakes for the suppertime. The pre-made meals would be withdrawn once a satisfactory nutritional menu had been agreed and arranged. They told us, "We aim to collect information from the residents about what they like and don't like in the way of food as well as any dietary needs". They went on to say, "I want the residents to be involved in the planning the menu; have food on the menu that stimulate their senses".

The manager told us the cook would be sent on further training to ensure they had the knowledge in providing older people with an adequate nutritionally balanced diet and were aware of potential allergens and special diets. They would also receive support and information from other services which support people with dietary needs such as the dietician.

The design and decoration of the home did not promote the well-being and independence of people especially for those people who live with dementia or have a cognitive impairment. Some people's bedrooms had been personalised however the communal areas such as the lounge and dining room were not homely or provided very little sensory stimulation. There were limited opportunities to help people become familiar with their environment such as coloured walls or personalised memory boxes outside their bedrooms. One person said, "Sometimes I get a little lost out there".

People told us they were referred to other health care professionals when they required additional care or treatment. A visiting health care professional confirmed staff contacted them appropriately to seek additional support and advice. They said people's care records had improved and generally reflected their needs. We were told by the deputy manager that links and communication between the home and the local GP surgery had improved. The manager had formed links with the mental health teams to review the needs of people who had mental health problems.

People were supported by staff who had been trained and supported to carry out their role. A new training plan was now in place which monitored staff training. The manager said, "Myself and the deputy manager are now overseeing the staff training. We are collating information about staff and finding out the strengths and weaknesses in our staff skills. It is our priority to address staff training in the new year". Most staff had now completed training considered as mandatory by the provider, such as safeguarding people and health

and safety training.

The manager was in the progress of developing a series of competency tools which could be used to check if staff were competent and adequately skilled to carry out specific aspects of their role. The competency tools were being reviewed by an external organisation to ensure they met the clinical standards required such as pressure care and catheter management. The manager said, "Once the competency tools have been signed off we will be using them to review the skill base of staff and then develop an action plan to address their training needs". The manager told us they were also reviewing staff's personal training needs through regular individual meetings with staff.

Staff who showed potential or an interest in a subject such as moving and handling people or infection control would be supported to develop their knowledge and training skills to allow them to train other staff members. Care and non-care staff had been supported to undertake a national qualification in health and social care and food safety. Qualified nurses were being supported through meetings and training to keep their nursing qualifications in line with the required national standards.

The home used a range of training schemes to ensure staff were knowledgeable in their role. New staff attended a four day induction programme which incorporated the care certificate. This helped the manager to monitor the competences of staff against expected standards of care. Their induction also included training; shadowing experienced members of staff; reading people's care plans and documents relating to the home such as policies and procedures. One new member of staff said, "This job is better than I thought it would be, we are supported and kept up to date".

Staff confirmed that they were now receiving regular support both formally and informally. One staff member said, "The support we get has definitely improved". The home's action plan showed that staff would receive an annual appraisal of their performance and skills in spring 2016.

We recommend that the service considers the national guidance and principles of Do Not Resuscitate Orders.

We recommend that the service seeks advice and support in relation to providing an environment that orientates people to their surroundings.

Good

Is the service caring?

Our findings

We received positive comments from people and their relatives about staff. People told us the support they received was caring and friendly. One person said, "The girls and the nurses are lovely, one in particular. She's wonderful. I don't know what I'd do without her" and "They are nice girls. Much nicer now, more chatty". Another person said, "They do look after me. They do their best". Family members supported this view. One relative said, "My relative is looked after exceptionally well". Relatives told us they were welcomed into the home and communication from staff had improved.

We observed staff interacting with people throughout our inspection. Most people sat in their bedrooms or one of the lounges throughout the day. Whilst the staff approach was caring and kind, their interaction with people was sometimes limited to when they supported people with their practical needs.

Staff approached people in a dignified manner. They spoke to people politely and gave them time to speak and answer questions. Staff cared for people respectfully. They told us how they spoke to people in a respectful manner. One staff member said, "It's important that we speak to the residents as a person not as a child". We saw warm exchanges between people and staff when they supported them with their personal care needs. Staff addressed people by their first names in a friendly and respectful way. Another staff member said, "It's important that we treat people equally. I ask them about their day. We know the residents really well so I know about them and what they like to chat about. I like to make them smile and be happy".

People were encouraged to remain independent and staff gave the appropriate amount of support so people could maintain their independence. For example, one person said, "They (Staff) let me wash my face and hands and they do the bits I can't reach. Then they get my clothes out and say 'What do you think?' and get some different ones out if I ask them to". A relative confirmed that staff encouraged people to become more independent. They said, "It's been better over the last year. They're trying to make my relative more independent. They can now wheel them self about now". We saw a nurse encouraging a person to walk from their bedroom to the lounge to eat their lunch.

Staff were able to tell us about the needs of people who weren't able to express themselves. They gave us examples of how they supported people if they become upset or needed reassurance. People who were able to express their views told us, "I'm looked after. This is a nice place and they keep track of you. They do look after me well".

Staff spoke fondly of people and their relatives. They showed concern for people's well-being. A staff member said, "We are here for the residents. We need to do a good job for them". People's privacy was respected. Staff knocked on people's bedroom doors and waited to be invited in before they entered the room. Staff talked to people in a confidential manner, ensuring they spoke discreetly when talking about private and personal matters and were amongst other people.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, people's individual care and treatment plans were not being recorded in line with their needs and people did not have any meaningful purpose to their day. During this inspection we found significant improvements had been made in this area. However there were still some inaccuracies in people's care records, although we found there was no negative impact on people. The manager told us they planned to implement a new care planning system which would address any gaps in people's records. An activity coordinator had been employed to ensure people's social and recreational needs were being met.

People were supported to have care records which reflected how they would like to receive their care, treatment and support. Information about people's personal backgrounds likes and dislikes and things which were important to them had been recorded. Their care records included information that enabled staff to monitor the well-being of people. Where people's health had changed, it was evident that staff had worked with other health care professionals to gain additional advice and support.

However, there were still some gaps and shortfalls in the quality of people's care and their records. For example, a dietician had made recommendations about the volume of fluids that one person should have each day. Records showed this person had not received the recommended amount. There was no explanation for this shortfall and what actions had been taken to address it. Records also showed that one person should be checked regularly but their records didn't state why they should be checked or what they were checking for.

People's care requirement's had been reviewed monthly; however there was no consistent approach recording people's changing needs. This meant people's care records did not always reflect their current needs. For example, the pressure area assessment of one person had not been consistently reviewed and updated monthly as in line with the home's policy. A tool used to assess and review the level of pain experienced by one person had not been reviewed. This meant staff were unable to assess if this person's level of pain had changed.

People's daily notes about their wellbeing and the care they had received were not consistently recorded. The daily notes were often task oriented and did not describe their emotional and social well-being.

The manager and deputy manager was aware of the inconsistencies in people's care records and were about to implement a new care planning system. The manager said, "We need a system that is easy so staff can access the residents care records easily and they can be updated quickly". We were told they were planning staff training on the new care records. One visiting health care professional told us they felt that people's care records had improved and staff were more responsive to people's needs.

A new pre-admission protocol was in place to ensure that people were fully assessed before they moved into the home; this ensured that staff could meet their needs. The manager said, "New residents will be fully assessed by a nurse before a decision is made to move them in. New pre-admission care documents were in

place and being used to support the admission process.

People's social and recreational needs were not always met. People had limited opportunities to explore and engage in their personal interests. People were left for long periods with little social interaction. For example, one person occupied themselves in the lounge by folding a piece of paper that they had found. Staff did not offer this person an alternative activity or to find out if this was what they wanted to do.

However, the home had recently employed one activity coordinators. We were told their role was still being developed and they had been tasked with speaking to every person who lived in the home to find more about their personal interests and backgrounds. They told us, "I plan to find out as much as possible about the residents life histories, likes and dislikes, and interests from the resident themselves and from their families". The manager said, "Activities for residents has not really been explored before with residents at Summerfield so we need to find out what they like and what they want to do". The activities coordinators were being supported to attend a local activities network forum to learn more about providing activities within a care setting.

People and staff told us that activities had started to be offered to people such as gardening, music and trips out. An activities programme was displayed on the notice board which included activities such as card games and bingo. The activity coordinator planned to extend the range of group and individual activities being offered. One person said, "They (staff) take me down into the garden and a carer takes me to Asda". Another person said, "We've had carol singing. I do enjoy it. The Minister came; he was very nice and shook my hand". The activity coordinator told us they had arranged that a member of the local clergy would be holding services in the home every month. They had also plans to invite people from the local community to visit the service and have a cup of tea with people living in the home. People had access to the hairdresser or could choose to use their own hairdresser. Pet therapy had been booked for the following week. Whilst people had been engaged in activities there were limited records of how much they had participated and whether they enjoyed the activity.

People were informed of information and events about the home. The manager had started to produce a monthly newsletter for people and their relatives which kept them updated of changes in the home and forthcoming events, such as the introduction of the activities coordinators.

A customer satisfaction survey had recently been sent out to people. Some of the completed questionnaires already received by the manager were mainly positive about the care people received. The results would be analysed by the manager and discussed at the residents and staff meetings. The manager said, "We plan to send out surveys every quarter, so we will be sending out surveys to health care professional next quarter".

Residents and relatives meetings were held regularly to give people the opportunity to raise concerns and make suggestions about the home. The meeting had been held at different times to ensure relatives had the opportunity to attend. The minutes of the meetings were included in the monthly newsletters.

The home's complaints policy was displayed on the notice board to assist people and their relatives with how to make a complaint if required. The home had received four formal complaints since our last inspection. The complaints had been dealt with in line with their procedure but documentation of the full investigation and outcome was inconsistent. The manager said that all complaints would now need to be viewed and signed off by her to ensure people's complaints were satisfactorily dealt with and recorded in line with the home's complaints policy.

Good

Is the service well-led?

Our findings

The home had made some significant improvements since our last full inspection in June 2015. During this time the home had been managed by an external care management company who had been involved in the improvement of the home. More recently, a new manager had been recruited to run the home and had been in post for three months at the time of this inspection. They were applying to be the registered manager of Summerfield Nursing Unit with CQC.

The manager had recognised the challenges the home faced and was aware of the shortfalls of the quality of service being provided. The manager was passionate about developing the home and ensuring people were safe and receiving high quality care. They were undertaking courses and carrying out personal research to increase their own clinical and management knowledge.

The manager told us their biggest achievement had been to improve communication in the home especially between staff. We were told that this had been done through regular meetings with staff to ensure they were kept up to date with the progress of the home. This was confirmed by staff and records of minutes of the meetings. This had resulted information about people's well- being between communicated between staff and recorded to ensure people received care which is consistent.

The manager held a weekly meeting for all heads of departments and significant other members of staff to attend. The aim of the meetings was to highlight and share any concerns about people's well-being and events which may affect the running of the home. Other meetings such as health and safety meetings and general staff meetings had started to be implemented to discuss and monitor the quality of the service. Actions had been taken as a result of the home's meetings such as people were being encouraged to use a cup to drink their drinks rather than a beaker and straw.

The manager had also started to develop group supervisions sessions to reflect on issues and events in the home. For example, staff had discussed and reflected on an incident of a person when there had been conflict about the medical intervention required when they became ill. This was also followed up by the deputy manager who observed staff and reviewed the management of this person's medicines.

The care management company had recently carried out an audit of the quality of service provided. The manager said, "The audit was useful and it has given us a benchmark of where the home is at and what areas still need to improve. We are working on the action plan". The manager was aware of the improvements that had been made but was also aware of the continued shortfalls in the service being provided. The manager said, "I know we still have a lot of work to do but I am confident that Summerfield will be a good home". They shared with us their vision of the home including plans to develop the unoccupied units of the home. However, we were told they were prioritising their progress and concentrating on making improvements directed by their action plan. They said, "We need to get it right for the people who live here before we open up the other units".

People spoke positively of the manager. We received comments such as; "Very good, she is" and "She is a

nice person. She came to see me as I was a bit cross". This person told us how the manager addressed the issue immediately.

Staff had gone through a period of uncertainty and lack of permanent leadership during the past 12 months. However, the new manager and deputy manager had brought stability to the home. Staff complimented the manager and deputy manager on their support and their commitment to improve the home. One staff member said, "Whilst the managers have been supportive they also taken a step back in places to allow us to make more decisions and try new things out". For example, staff had offered people with dementia their meals on coloured plates. Research has suggested that people's food intake increases when they eat off coloured plates.

All staff had been asked to complete a health declaration. We were told the aim of this exercise was to reduce the sickness rate by understanding staff's health needs and to make reasonable changes to their work patterns where possible to prevent further decline in their health. The manager was in the process of reviewing the home's policies and protocols to provide staff with up to date guidance.

The manager and senior staff had carried out some checks to monitor the quality of the service being provided such as health and safety and infection control. However, there were inconsistencies in the records of the actions which had been taken when a shortfall had been identified. The manager told us that the quality and scope of audit checks would improve. They showed us a timetable of a schedule of audits and management tasks to be completed the following year such as kitchen checks, medicine audits and annual appraisals of staff. We were told that the heads of departments such as housekeeping would also be expected to carry audits of their own departments which would be checked by the manager. The manager was in the process of reviewing the home's policies and protocols to reflect the running and systems of the home.

The manager was starting to engage and network with the local community. They had arranged an open day as well as pamper evening to encourage people who were connected to the home and the local community to visit the home. The manager said, "We want to make the home fun and personalise the home to be more friendly and homely". The manager spoke of increasing the numbers of volunteers to work in the home as well as encouraging students for work experience.