Ashcare (Summerfields) LTD

Summerfield Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Summerfield Care Home is a residential care home providing personal care for up to 21 people aged 65 and over who may be living with dementia. At the time of the inspection, 13 people were being supported.

Summerfield Care Home accommodates up to 21 people in one adapted building.

People's experience of using this service and what we found
People did not receive a safe service because there was not always enough staff to support them.
People's risks were not promptly identified and managed. Staff did not always know how to support people safely because they had not had all the training they required and some plans were not in place to follow.

Medicines were not always safely managed and we could not be assured people were protected from the spread of infection. People were not always protected from the risk of abuse because systems were not in place to identify, report and investigate concerns.

The management team and provider did not have thorough oversight of the service and did not have systems in place to keep people safe and to identify areas for improvements. There was not a positive culture in the service.

Feedback was gathered from people, relatives and staff. Staff knew how to raise concerns outside of the service.

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

Rating at last inspection
The last rating for this service was requires improvement (published 6 June 2019).

Why we inspected
We received concerns in relation to the safety of people being supported. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate. This is based on

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

The provider has taken action to mitigate risks we identified including increasing staffing levels.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Summerfield Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing, safe care, safeguarding people from abuse and improper treatment and governance at this inspection.

Please see the action we have told the provider to take in relation to safeguarding people from abuse and improper treatment at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We have met with the provider prior to this report being published to discuss how they will make changes to ensure they improve their rating. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Summerfield Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by an inspector and an assistant inspector.

Service and service type
Summerfield Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with six members of staff including the deputy manager, care workers, domestic staff and the chef. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a visiting health professional.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two relatives on the telephone to gather feedback on their experiences of the care provided to their family members.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- There was not always enough staff to safely meet people's needs and ensure their safety.
- Staff told us they had to prioritise whose needs they met because there wasn't enough of them to meet everyone's needs. One staff member said, "We try our best to meet everyone's needs but we need to prioritise them because we can't always do everything." Another staff member said, "It is hard in the evening. When it is a full house with only two staff it is hard. We need to think about what needs doing first and who is most in need."
- At tea time, we saw there was not enough staff to keep people safe. People who were at risk of falls were attempting to mobilise without support because staff were unable to observe. This left them at very high risk of falls. We also saw a person at risk of choking did not have the level of supervision they required when eating and were able to access food that was unsafe resulting in them choking.

The above evidence demonstrated that sufficient numbers of suitably skilled staff were not always deployed. This placed people at serious risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They increased the number of staff during the daytime and started to use a 'dependency tool' to ensure they appropriately assessed the number of staff required to meet people's needs in the future.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Staff were not always aware of peoples risks. One staff member said, "There are quite a few [people] at risk of falling, I'm not sure who though."
- When risks were identified, action was not always taken to reduce the risk of harm to people. For example, some people had damage to their skin with no plan of care in place and no medical advice or treatment sought leaving them at serious risk of further skin breakdown. Other people had experienced falls and staff had not followed policies and procedures to ensure their safety and reduce the risk of reoccurrence. One staff member said, "I'm not sure if anything is in place, I don't know."
- Staff had not received training to support them to manage people's individual risks for example, epilepsy and behaviour that may challenge. Staff were not clear on how to support a person with their behaviour and we saw they received inconsistent support.
- The provider did not have suitable systems in place to ensure they could learn lessons when things went wrong. For example, incident and accident records were not always reviewed in a timely way to ensure lessons could be learned and reoccurrence prevented. This meant incidents were likely to happen again.

Using medicines safely

● Medicines were not always safely managed.

● Staff had stopped giving one person one of their prescribed medicines without seeking medical advice, this could have been dangerous to their health and wellbeing.

● Topical creams were left out in people's bedrooms and not secured in a locked cupboard. Some people were living with dementia and other conditions which meant they were at risk of ingesting medicines.

● Topical creams did not have clear instructions for staff to follow. It was not always clear where, when and how topical medicines needed to be applied which meant there was a risk that people would not get their medicines as intended by the prescriber.

● Some medicines stock counts did not match what should be in stock. This meant we could not be assured that people were receiving their medicines as prescribed.

Preventing and controlling infection

● The provider was not meeting social distancing rules or promoting safety through the layout of the premises. For example, the lounge and dining areas were not set up in a way that prompted people living with dementia to socially distance.

● The provider was not promoting safe hygiene practices or ensuring staff were using PPE effectively and safely. For example, we observed some staff supporting people to eat without the required PPE and staff were not bare below the elbow or free from jewellery. This increased the risk of infection spreading through poor infection control practices.

The above evidence demonstrated that people were not supported safely, medicines were not always managed safely and infection prevention and control practices were not always adhered to. This placed people at significant risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse

● Staff told us they had received training in safeguarding adults and they could tell us about the types of concerns they would report. However, they had not always recognised potential safeguarding concerns in practice.

● There was a lack of effective systems in place to ensure that concerns were reported to appropriate authorities in a timely manner. For example, we found that staff had completed body maps when they found unexplained marks or bruises on a person's body but it was unclear what should then happen to that body map. It was not always reviewed by a senior person, reported and investigated to ensure peoples safety. This meant there was a risk that concerns could go unreported.

● The service had never reported any concerns to the local safeguarding adults since their registration over three years ago. There was a concern that incidents were not being recognised, reported or investigated to ensure people were protected from the risk of abuse.

The above evidence demonstrated that systems and processes were not established and operated effectively to investigate any potential abuse. This placed people at risk of harm. This was a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

At our last inspection we recommended the provider ensured records were accurate and up to date and audits were robust to identify shortfalls so immediate action could be taken. We found improvement had not been made and we had concerns about how this effected the safety and quality of the service provided.

- The registered manager was on a period of planned leave. There was an acting manager but no handover had taken place and the acting manager was not familiar with systems in place or some key aspects of the management role. This meant we were unable to view some records we needed during the inspection, including the staff training matrix.
- There was no effective governance system to allow the provider to assess and monitor the safety of the services provided. Some areas of care delivery were not checked at all including the application of topical creams and daily records. This meant the provider could not be sure people were getting the care they needed, leaving them at significant risk of harm. It also meant that concerns and areas for improvement were not identified.
- There were some audits in place but these were ineffective. For example, the medicines audit did not cover topical creams and the pressure prevention audit completed in August 2020 had an action to devise a staff competency assessment but this had not been completed. This meant audits in place did not identify issues we found on inspection and therefore issues had continued with no improvements made, leaving people at risk of unsafe care.
- Monthly reviews on people's care plans were not effective at ensuring they contained accurate and up to date information about people's changing needs. For example, one person's food and fluid care plan did not contain information about their thickened fluid and specialist diet. This care plan had been reviewed with no changes, so the review was ineffective. There was a risk that new or agency staff would not know the person required thickened fluids.
- The provider and acting manager lacked knowledge relating to key areas of legislation.

The above evidence demonstrated that governance systems were not established or operated effectively. This placed people at risk of harm. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There was not a positive culture in the home. We heard some staff repeatedly tell people to sit down when they stood from their chairs, rather than find out what they needed help with or wanted to do. This was very poor practice that had become accepted within the service and could significantly impact on people's wellbeing and quality of life.

● Staff had mixed responses about whether the management team were supportive. Some staff felt they couldn't speak openly with management because previously their confidential information had been shared with other staff members.

● Some staff did feel supported and regular staff meetings were held. However, our observations showed this did not contribute to building a positive, inclusive and empowering culture.

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

● Relatives we spoke with were happy with the service their family received and said they were kept well informed about any changes with their family members. One relative said, "The home keep in touch and let me know what is going on with [my relative]".

● Feedback was obtained from people, relatives and staff and in 2019 it was analysed and an action plan developed in response to people's feedback.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was no system to ensure potential safeguarding concerns were recognised reported and investigated promptly.

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 People's risks were not always promptly identified, managed and mitigated to ensure they recieved safe and treatment.

The enforcement action we took:

We imposed a condition on the provider's registration. This required them to take additional action to evidence to us that they are taking action to become compliant with the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no effective governance system in place to enable the provider to monitor and the manage the safety and quality of the services provided.

The enforcement action we took:

We imposed a condition on the provider's registration. This required them to take additional action to evidence to us that they are taking action to become compliant with the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough staff to keep people safe and meet their needs.

The enforcement action we took:

We imposed a condition on the provider's registration. This required them to take additional action to evidence to us that they are taking action to become compliant with the regulation.