Ashcare (Summerfields) LTD

Summerfield Care Home

Inspection report

12 Burton Road
Branston
Burton On Trent
Staffordshire
DE14 3DN

Tel: 01283540766

Date of inspection visit:
09 June 2021

Date of publication:
05 July 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Summerfield Care Home is a residential care home providing personal care to 8 people aged 65 and over at the time of the inspection. The service can support up to 21 people, some of whom may be living with dementia.

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

People's experience of using this service and what we found
Improvements had been made, however new processes and systems needed to be further embedded into practice to ensure the service was consistently safe and well-led.

New systems had been introduced to ensure people were safeguarded from abuse and avoidable harm. However, these were still not being followed consistently, and we found that some incidents had not been reported to the safeguarding authority when required.

Improvements were required to ensure people had their medicines as prescribed.

Staff knew people's risks and there were plans in place to mitigate risks and keep people safe. However, these were not always written down. People were protected from the spread of infection.

There were enough staff on shift to meet people's needs and people did not have to wait for the support they required. There were plans in place to recruit more staff.

The provider and registered managers had improved oversight of people's risks and needs. However, improvements were still required to ensure staff were following new systems and that governance systems were identifying issues and effecting change.

Relatives felt that staff were caring, and staff felt well supported and enjoyed working at the home.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 17 December 2020 and supplementary report published 25 February 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made but they needed to be fully embedded and sustained and the provider was still in breach of some regulations.

This service has been in Special Measures since the last inspection. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 17 November 2020. Four breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding service users from abuse, staffing and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm whether they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.
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.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 continued breaches in relation to medicines, safeguarding and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. Following the last inspection, we imposed conditions on the provider's registration which required them to update us monthly on their progress. These conditions will remain in place to allow us to closely monitor the service and ensure improvements are progressing. We will also 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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 one 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 two managers 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 three people who used the service and three relatives about their experience of the care provided. We spoke with eight members of staff including the provider, registered managers, care assistants and the cook. We observed interactions between people and staff in communal areas. We reviewed a range of records. This included three people's care records and medicines records. We looked at three 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.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found 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.

Whilst some improvement in this area had been made, not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● We found that staff had completed a body map detailing unexplained bruising to a person's body. The staff member thought they knew the cause of the bruising, but they took no action to confirm or deny this, or to report the concerns, which left the person at risk of further harm.
● Body maps were checked monthly by the registered manager. The body map we found had not yet been checked which meant the registered managers were unaware of the unexplained bruising. This meant systems in place were not sufficiently robust to ensure safeguarding concerns were promptly recognised and reported.
● There was also an occasion where an allegation of abuse had been made. Although the provider took action to reduce the risk of harm, they did not report the allegation to the local safeguarding authority in line with safeguarding adults' procedures.
● Staff told us they received training about safeguarding and told us how they would report any concerns. However, the above examples showed this had not always happened in practice.

The system for ensuring people were safeguarded from abuse and improper treatment was not sufficiently robust. This placed people at risk of potential harm. This was a continued breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection, the provider had recognised and reported concerns to the local authority in line with safeguarding procedures. They had taken action to make improvements when concerns had been identified. However, the above examples showed that safeguarding procedures needed to be fully embedded so that staff respond quickly and appropriately to any concerns identified.

Using medicines safely

At our last inspection 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.

Whilst improvements had been made in all areas, not enough improvement had been made to medicines management at this inspection and the provider was still in breach of regulation 12.

● One person was prescribed paracetamol and codeine, as and when required (PRN), for pain relief. We saw they communicated pain to staff throughout the day, who acted and administered paracetamol. We asked a staff member, who was responsible for administering medicines, how they knew whether to administer paracetamol, codeine or both and they stated they did not know. There was no guidance or protocol for staff to follow to show when or why codeine should be administered, which meant the person was at risk of not having appropriate pain relief medicines, as intended by the prescriber.
● One person's medicines did not have their name or prescription label on. They had been at the home for 13 days and the home had not confirmed with a GP or pharmacist what medicines had been prescribed for them or the frequency. This left the person at risk of harm from not receiving their medicines as prescribed.
● Staff had completed a handwritten medicines administration record (MAR) for some people's medicines. MAR is a record of all prescribed medicines for the individual. We found one person's MAR stated they should have Laxido (a medicine for the treatment of constipation) once daily. However, the prescription label said they should have Laxido two to four times a day. A second person had countersigned the MAR and they had not noticed the mistake. This left the person at risk of constipation because they were not receiving their prescribed medicines as often as prescribed.
● Some people were prescribed variable doses, for example, one to two tablets to be administered. However, staff were not always recording whether one or two tablets had been administered which left people at risk of overdose or of not receiving enough medicine. It also meant it was impossible to check the correct stocks were in place, that matched what had been administered. This issue had been identified in audits but continued to happen.
● Topical creams were still left out in people's bedrooms and not secured in a locked cupboard. Some people were living with dementia which meant they could be at risk of ingesting medicines. This was an issue at the last inspection.
● Some topical creams still did not have clear instructions for staff to follow. It was not always clear where, when and how topical medicines needed to be applied because body maps were not always completed. This meant there was a risk that people would not get their medicines as intended by the prescriber.

Improvements to the medicines administration system had been made which meant more checks were being carried out and stock counts were now more accurate to show people received their medicines as prescribed. However, safe medicines systems needed to be embedded into practice and they were not currently robust enough to demonstrate medicines safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection, the provider and registered manager had improved their oversight regarding medicines. They had increased checks and implemented new systems and procedures. However, the above examples showed that these needed further embedding to ensure consistently safe medicines management.

Staffing and recruitment

At our last inspection 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● We saw there was enough staff to keep people safe and to meet their needs.
● A staff member said, "I think there's enough staff on shifts, but we would need more if we had more residents."
● The provider was in the process of recruiting more staff as staff were currently covering extra shifts due to staff sickness. This put pressure on the existing staff team.
● Improvements had been made to staff training and staff were now offered more training and compliance was better monitored. The provider continued to make improvements to the training offered and induction process.
● Staff were recruited safely and had appropriate checks in place. However, the provider needed to make improvements to ensure any gaps in employment history were explained and to ensure recruitment records were clear and easily accessible.

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

At our last inspection people were not supported safely as risks were not suitably managed. This placed people at significant risk of harm. Improvement had been made at this inspection.

● Staff knew about people's risks and how to manage them.
● Improvements were needed to ensure care plans and risk assessments reflected the measures in place to manage risks, so that any new staff had access to this information. However, the registered managers and provider had improved knowledge and oversight of people's risks and had taken action to mitigate risks. For example, when people were at risk of falls, they had measures such as chair and bed sensors, sensor mats and waking aids.
● The provider now had systems in place to learn lessons when things went wrong. For example, incidents and accidents were monitored monthly to look for trends and action was taken to prevent reoccurrences. These systems needed to be fully embedded and sustained to ensure ongoing improvement.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Touch point cleaning needed to be increased and cleaning schedules needed to be clearer and easier to access. The registered manager was already working on these improvements.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 found 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.

Whilst some improvement in this area had been made, not enough improvements had been made at this inspection and the provider was still in breach of regulation 17.

● Daily, weekly and monthly medicines audits were in place. However, these were not always effective. The temperature of the medicines room was not being checked or recorded. This meant there was a risk that medicines could be stored at an inappropriate temperature which may affect their efficacy. Daily and weekly audits had been completed and stated the room temperature was being checked but it was not. This meant the audits had not been effective in identifying this area for improvement.
● The daily, weekly and monthly medicines audits had not been effective in identifying the issues with medicines that we found during the inspection. For example, none of these had identified the mistake on the handwritten MAR.
● Audits in place had not identified the records issues that we did. For example, some care plans and risk assessments were missing key information that staff needed to ensure people received safe care. Audits had not identified this issue.

Improvements had been made to the overall governance systems in place. However, new processes and systems need to be further embedded and then sustained to ensure continuous improvement. This was a continued 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 had been positive changes to the culture within the home. People told us they were happy, and we observed people were able to spend their time as they chose.
● An additional manager had been registered and staff told us they were approachable. A staff member said, "Absolutely I could approach the manager with anything. She is a very welcoming manager."
● Staff felt more relaxed and felt supported and included in the running of the home. A staff member said, "[Registered manager] and [provider] are both very approachable. We have regular staff meetings and they encourage us to approach them with anything at all and we do. Meetings are not just to listen to managers, it's a chance to say if you have a problem and work out what we can do together to change it."
● Staff comments also included, "I love working here, the staff are wonderful," and "This is a great place to work now."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives we spoke with were happy with the care provided to their relatives and felt they could approach the provider with any issues. However, relatives did not always know who the registered manager was.
● The provider was in the processes of formally gathering feedback from people, relatives, staff and professionals via questionnaires. They planned to take action in response to feedback.
● Some relatives fed back that the décor of the home was poor and needed updating. The provider had a plan in place to address this and we will check this at our next inspection.

Working in partnership with others
● The service had worked alongside other professionals to bring about improvements. For example, the infection, prevention and control team had provided advice, support and training for staff and we saw they had listened and used the input to help make improvements at the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed. There was a risk that people would not receive their medicines as prescribed.

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 We found two examples when the provider had not referred incidents to the local safeguarding authority when they should have been. This left people at continuing risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate an effective governance system.