Summerfield Medical Limited

Summerfield Nursing Unit

Inspection report

58 Whittington Road
Cheltenham
GL51 6BL
Tel: 01242 259260
Website: www.summerfieldnursing.co.uk

Date of inspection visit: 24 August 2015
Date of publication: 22/09/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service responsive?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on1 and 2 June 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to people's safety and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to people's care records.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Summerfield Nursing Unit on our website at www.cqc.org.uk.

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 28 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.

The provider had recently appointed a new manager for the home who would be applying to be registered with the Care Quality Commission as required by their conditions of registration. 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. An 'improvement lead' from a care management company

Summary of findings

acted on behalf of the provider and supported us with our inspection as the new manager was not available on the day of our inspection. The provider had commissioned the care management company to help improve the quality of the service.

At this inspection we found the support and care provided was now safe and responsive to people's care needs. The layout and detail of people's care records had been reviewed and updated. People's individual risks were being assessed, monitored and recorded. This gave staff with sufficient information to guide them on how best to deliver care that was centred on people's needs and helped to reduce risks. There were improved links with other health care professionals.

The knowledge and clinical skills of staff was being monitored and updated to ensure people were cared for by staff with current care practices. The medicines policy had been updated to give staff clear guidance on how people's medicines should be managed. Protocols were in place for people who needed their medicines 'as required'.

Summary of findings

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

This service was now safe.

We found that action had been taken to improve safety. People's risks were being assessed and managed by staff who had been trained to care for people with complex needs.

People's medicines were being managed and administered in line with their medicines policy.

We could not improve the ratings for responsive from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Inadequate

This service was now responsive.

We found that action had been taken to improve people records to reflect their needs. People's care plans were now focused on their needs. Detailed risk assessment and monitoring tools were in place.

We could not improve the ratings for responsive from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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.

We undertook an unannounced focused inspection of Summerfield Nursing Unit on 24 August 2015.

This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 1 and 2 June 2015 had been made. We inspected the service against two of the five questions we ask about services: Is this service safe and is the service responsive? This is because the service was not meeting some legal requirements.

Our inspection team consisted of two inspectors. We spoke with three people using the service, one relative and two members of staff and the management team, including the deputy manager and the improvement lead. We reviewed the records of six people using the service. We also spoke with one health care professional.

Inadequate

Is the service safe?

Our findings

At our inspection in November 2014, we found that people were not safe as their personal needs and risks were not being managed effectively. The provider sent us an action plan to tell us how they would ensure people were kept safe in the home. On 1 and 2 June a full comprehensive inspection was carried out to follow up on these concerns. Whilst we found some improvement had been made people's health needs were not being adequately met and therefore people still remained unsafe. CQC warned Summerfield Medical Limited that they must take immediate improvements within a given timescale at Summerfield Nursing Unit. On 24 August, we revisited the home to check if they had met the legal requirements.

At this inspection we found that actions had been taken to improve the safety of people. Their care, risks and medicines were now being managed effectively. The provider had taken an organised approach to assess the processes and systems being used to ensure people who lived at Summerfield Nursing Unit were safe. They had addressed the shortfalls of the risks and care being provided; identified staff training and reviewed the management of people's medicines. The home had engaged with the local authority who had provided additional support and guidance in staff training, clinical interventions and care assessment tools.

People were being supported by staff who had refreshed their clinical knowledge and were being supported to carry out their role. Gaps in staffs' clinical training were being identified through regular supervision and observations of their care practices. Some staff had received additional clinical training such as catheterisation. Plans were in place to continue to address the skills and knowledge of staff through training, mentoring, peer support and team meetings. National clinical guidance and leaflets were available for staff to refer to as required. We were told the new manager had an established history in training health care staff and would be overviewing and monitoring the training needs of all staff.

People's personal risks of harm and injury were now being identified and mainly being managed well. Staff were knowledgeable about peoples' individual risks and were able to tell us how people were monitored to reduce the risks of further deterioration in their heath. The provider had implemented nationally recognised assessment tools to identify if people's health was at risk such as the risk of malnutrition or pressure ulcers. The nurses had initially started to weigh people weekly to gain an understanding of their present weight. People who maintained an ideal weight were no longer checked as regularly. Others who had been identified as at risk of weight loss or gain continued to be monitored. Staff used an assessment tool to identify the level of risk of malnutrition. Whilst these tools were being actively used, they weren't always being completed correctly. The improvement lead was aware of this and was planning a training session to update staff on the correct usage of this tool. People's care plans gave information on how to support people with their eating and drinking and to increase their calorie intake.

Staff were aware of the importance of documenting incidents or any interventions by visiting health professionals such as GPs. The home had developed improved relationships with their local GP surgery. The improvement lead said "The GP visits weekly and also responds quickly to any of our concerns." Records showed the tissue viability nurse had been involved in assessing, implementing and evaluating interventions of people who had compromised skin integrity.

The home was staffed by sufficient numbers of staff. People's call bells were answered promptly. Staff told us people who were not able to use their call bells were checked regularly. Records of regular safety checks on people in their rooms confirmed this.

Each person had a fire risk assessment and evacuation plan which provided staff with information on how to support people in the event of a fire. We were told that the home held regular fire drills.

The management of people's medicines had improved. We observed people being given their medicines by a nurse in a respectful and dignified manner. Protocols were now in place for people who required their medicines 'as required'. Guidance was provided for staff such as the reasons why medicines should be administered and circumstances which should be reported to the GP. There was evidence in people's records that GPs had been consulted if there had been a concern about people's medicines for example the GP had been consulted when one person had continually refused their medicines.

The provider had implemented a monthly audit to monitor the management of people's medicines. The audit had

Inadequate

Is the service safe?

highlighted issues about stock control of people's medicines. This was investigated and raised with the relevant authorities. The provider has now subsequently reviewed the frequency and contents of their auditing systems to reduce further errors and identify concerns in a more timely manner. A new pharmacist was now being used by the provider. The new pharmacist had carried out training with staff to ensure they were competent to order and manage people's medicines using their systems. Further e-learning training on effective medicines management had also been carried out by staff who were responsible for people's medicines. The provider has now implemented an observational tool to monitor staff competencies in dealing with people's medicines. The pharmacist had recently carried out an audit and made to some recommendations which were being addressed by the provider. A new medicines policy had been implemented to give staff guidance on the expected practices on how to manage people's medicines.

Whilst we saw improvements had been made in how people's care, risks and medicines were now being managed, we could not improve the rating for 'Is the service safe?' from inadequate because to do so requires consistent good practice overtime. We will check this during our next planned comprehensive inspection.

Inadequate

Is the service responsive?

Our findings

At our inspection in November 2014, we found that the service was not responsive to people's needs. The provider sent us an action plan to tell us how they would ensure people's needs were met. On 1 and 2 June a full comprehensive inspection was carried out to follow up on these concerns. We found whilst some improvement had been made people's health needs were not reflected in their care records and therefore the service still remained unresponsive to people's needs. CQC warned Summerfield Medical Limited that they must take immediate improvements within a given timescale at Summerfield Nursing Unit. On 24 August, we revisited the home to check if they had met the legal requirements.

At this inspection we found actions had been taken to improve and the needs of people were mainly being met. The provider had taken an organised approach to review people's care records and collate adequate information about people's physical, mental health and social needs. The home had engaged with the local authority who had provided additional support and guidance in staff training, clinical interventions and care assessment tools. Most staff had been trained in the process of producing care plans that were centred on people's personal, physical and emotional needs.

We were told they had used the basis of the old format of the care plan as the foundation of the new care plan. A new care plan was now in place for all people who lived at Summerfield Nursing Unit. Each part of the care plan, provided staff with information about the support they required in a specific area of their needs such as help to get dressed; the person's desired goals such as maintaining their independence in getting dressed and details of this was to be achieved.

We were told as a result of a recent local authority inspection a new index system had been implemented in everyone's care plans which meant staff could easily access relevant information about people.

Information in people's care records provided staff with the guidance they required to support people and to meet their needs. Risk assessments and monitoring tools were mainly being used effectively. Information about people's progress and wellbeing was being recorded. The home had introduced a nursing 24hr statement which captured relevant information about people's health and well-being depending on the medical needs. However these forms were not always completed consistently. For example, people's fluid intake was not always recorded on the form or there was not a clear record of when one person had been turned in bed for pressure relief on their skin. This meant the overview of people's well-being during a 24hour period was not always being captured accurately.

Details of how to care for people who required support or monitoring with their eating and drinking was recorded. For example, one person's care plan stated they were unable to eat and drink independently due to poor grip and limited arm movement and they required to be seated upright when eating. Records also stated this person needed to drink from cup or beaker with a straw and preferred to eat their meals in their own bedroom. Information and guidance was available for staff for people who required their nutrition and hydration via a feeding tube. Records indicated their feeding tubes were cleaned regularly.

Care plans relating to people's risk associated with their specific medical needs such as Parkinson's or diabetes were in place. These care plans gave staff clear guidance of how to support people and what actions to take if their medical needs changed. For example, the treatment of one person who had diabetes was clearly described. Records showed how staff should monitor this person's blood sugar levels and actions to take if they exceeded the desired levels.

Where people had been identified as being at risk of developing pressure ulcers, risk assessments had been put into place to address the issues of people's tissue viability. However, some risk assessments required more detail to give staff clear guidance on how to reduce the risk of further deterioration of the health of people's skin. Body maps were being completed which indicated where people's skin had broken down. Where photographs of people's wounds had been taken they had been named and dated. Treatment plans were documented to give staff guidance on how to promote healing of their wounds. This detailed the type of treatment and frequency of application. Evidence of the intervention of specialist such as tissue viability nurses was recorded.

Staff had tried to encourage people and their relatives to tell them a little more about their backgrounds, family histories and general likes and dislikes. Whilst this information was now available for staff to read, it was not

Inadequate

Is the service responsive?

always embedded into people's care plans. We were told the collection of this information was still on-going and the emotional and social part of the care plan was being developed. The improvement lead said, "We have been concentrating on people's risks and nursing needs, but we are aware that this part of people's care files are outstanding. This will most certainly be addressed when we have employed an activities coordinator."

Documentation showed that people had been referred to appropriate health care services when required such as the Speech and Language Team. The tissue viability nurse had been involved in assessing, implementing and evaluating interventions of people who had compromised skin integrity.

Staff were positive about the new care plans. There was evidence that people's care plans were being regularly reviewed and updated. The improvement lead told us, "We have started to implement regular audits on the care plans. Each time we can see an improvement." Information was documented and shared between staff during staff handover. Daily notes were completed about each person after every shift; however they did not always reflect a person's emotional and social needs or achievements.

Whilst we saw improvements had been made in people's care records, we could not improve the rating for 'Is the service responsive?' from inadequate because to do so requires consistent good practice overtime. We will check this during our next planned comprehensive inspection.