London Residential Healthcare Limited

Summerlea House Nursing Home

Inspection report

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Littlehampton
West Sussex
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of this home on 5 January 2015. Breaches of Regulation 9 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were found. After the comprehensive inspection we served a warning notice on the registered provider and registered manager of the service requiring them to be compliant with the Regulations by 12 April 2015.

We undertook this focused inspection on the 14 April 2015 to check they had met the 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 Summerlea House Nursing Home on our website at www.cqc.org.uk

A registered manager was in place A registered manager is a person who has registered with the Care Quality

Summary of findings

Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the registered provider and manager had not met the requirements of the Regulations to meet the fundamental standards.

Care records did not identify individualised plans of care for people, particularly those with specific health or social needs. Risk assessments in place had identified actions required to reduce risk for people who had fallen. However, there was no care plan in place which identified the specific needs or actions for people to respond to and reduce these risks.

Care staff did not access or inform care plans to ensure the care the person received was in line with their needs. Registered nurses prepared care plans for people which lacked information about their specific needs and these were not reviewed effectively.

Care staff responded to people's needs in a calm, kind and effective way. The environment of the Rosemead Unit had been altered to accommodate the needs of people who live with dementia although people had not been involved in the planning of this work.

A lack of leadership in the management of care planning and review meant staff were not aware of their responsibilities in the planning of individualised care for people.

Incidents and accidents were not always reviewed and appropriate actions were not taken to inform learning and make changes to people's care appropriately.

Audits of records were not used effectively to ensure the safety and welfare of people.

We found breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of this report.

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?
We could not improve the rating for this question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Is the service effective?
We could not improve the rating for this question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Is the service caring?
We could not improve the rating for this question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

Is the service responsive?
The service was not responsive.

People's care plans did not reflect their identified needs.

Staff were not aware of the need to understand, inform and review individualised plans of care for people.

We could not be assured people received the care they required in line with their needs.

Inadequate

Is the service well-led?
The service was not well led.

Policies in place to monitor the effectiveness and safety of the service were not being adhered to.

A clear lack of leadership and appropriate use of management processes such as audit meant people were not always aware of their responsibilities in ensuring people received the care they required in a safe and effective way.

Inadequate

Summerlea House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Summerlea House Nursing Home on 14 April 2015. This inspection was completed to check that improvements to meet legal requirements had been completed by the registered manager and provider after our comprehensive inspection of the service in January 2015. The service was inspected against two of the five questions we ask about services: Is the service responsive, and is the service well led? This is because the service was not meeting some legal requirements.

The inspection team consisted of two inspectors and an expert by experience in the care of older people. 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 our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered manager had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with nine people who lived at the home and five relatives to gain their views of the home. We observed care and support being delivered by staff in all areas of the Rosemead Unit. Staff in this locked unit supported people who were living with the advanced stages of dementia. We spoke with the registered manager and five members of staff, including two registered nurses and care staff. The operations support manager and the training and development manager for the registered provider was also present and spoke with us.

We looked at the care plans and associated records for seven people who lived in the Rosemead Unit. We looked at records relating to the management of the service including records of accidents and incidents, investigation records, staff meeting minutes and care record audits.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Requires improvement

Is the service safe?

Our findings

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

Requires improvement

Is the service effective?

Our findings

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

Requires improvement

Is the service caring?

Our findings

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

Inadequate

Is the service responsive?

Our findings

In our inspection on 5 January 2015 we found alack of consistent and effective plans of care were in place to meet the individual needs of people who lived with dementia. This was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We issued a warning notice to the provider and registered manager requiring them to be compliant with this Regulation by 12 April 2014.

Following our January inspection, the registered manager forwarded a copy of the action plan they and the registered provider had put in place to be compliant with these regulations. This stated all actions to be taken would be completed by 12 April 2015. We found at this inspection this plan had not been completed.

At this inspection we found the provider and registered manager had not addressed the issues we had raised with them in relation to meeting the individual needs of people who lived with dementia.

Each person on the Rosemead Unit had a folder of information containing care plans and records relating to the care they required. The provider's policy, "Assessment and Care Planning," dated 1 October 2014, identified the roles and responsibilities of staff to ensure that people's needs were identified and met in their care plans. This policy was not being followed as care plans lacked information on the support and care people required to meet their individual needs. They were not personalised and did not give clear information and direction to ensure staff could meet people's needs. Registered nurses completed care plans and reviewed these but care staff had not seen these.

For example, people who lived on the Rosemead Unit had a cognitive impairment resulting from dementia. As this condition progresses people commonly display agitation and what can be regarded as aggressive behaviour. Records showed incidents of physical aggression had occurred. Whilst risk assessments in place identified some people could become agitated or aggressive at times, care plans held no supporting information as to how staff could support people at these times. There was no information as to any triggers for these behaviours, or how staff should ensure people's safety at these times.

One member of staff told us, "Lots of people get aggressive or shout at each other. There are no guidelines, I don't refer to care plans, and I know what to do from my training about dementia." This demonstrated an acknowledgement and acceptance of aggressive and agitated behaviour on the Rosemead Unit without specific guidance for individual people and how they should be supported with this need. This concern had been identified during our visit in January 2015. The registered manager and provider had not addressed this need. We observed staff had an understanding of how to generally communicate and interact with people who lived with dementia, however the lack of understanding and information to support staff in how to individualise communication practices to meet the needs of people meant people were at risk of not having their individualised care needs met.

It is of note the provider's policy on Challenging Behaviour dated 1 December 2014 gives no information on the need for individualised care plans or actions for people who present with challenging behaviour. Advice was given in the policy on how to manage and report challenging incidents. However the registered manager had not ensured staff had followed the policy to inform the reporting of challenging behaviour in the Rosemead Unit. There was a lack of information in people's care records about the incidents which had occurred.

In January 2015 there was no policy in place for the management of as required (PRN) medicines At this visit we saw a policy for these medicines was in place, however this had not always been followed. For one person we observed they had been prescribed a sedative medicine for insomnia. This medicine had not been required between the dates of 30 March 2014 and 11 April 2015. However on the 12 April 2015 this medicine had been administered and a 'PRN Administration Record' had been completed stating the time of administration as 19:30hrs and the reason as 'Insomnia'. There was no supporting information as to the reason for this administration in the care records and no advice on the effectiveness of the medicine administered. We asked a registered nurse why this had been administered and they told us it was because the night staff were reduced in numbers and so the night time medicines

Is the service responsive?

had been given early to help them. The providers policy on the administration of PRN medicines states, "To ensure the medication is given as intended, a specific care plan for administration must be completed and reviewed monthly or when a change occurs." This policy had not been adhered to. The registered manager was not aware of this incident and we raised a safeguarding alert with the local authority in relation to this matter. We could not be assured the care this person received was in line with their needs at the time the medicines were administered.

Whilst some risks had been identified in people's care records, risk assessments were not always up to date, nor were appropriate actions in place to support these assessments. For example, people who were at risk of falls had a risk assessment completed to identify areas of concern for the person. However, no personalised care plans were in place to identify people's specific needs following this risk assessment. Risk assessments had not been updated after incidents of falls and actions were not always completed to ensure people's safety was ensured.

For one person who was at high risk of falls, staff identified they regularly would 'put themselves on the floor'. This person was reported to have fallen eleven times since January 2015. We could see evidence of one fall in care plans and records. A crash mat had been provided for this person to reduce the impact of any falls they may have. However, on two occasions we noted this was not in place when the person was sat in their room alone. Whilst risk assessments had been updated about the number of times this person had fallen, no care plans or actions taken were identified in care plans. We saw staff supported this person in a general way which reduced the risk of their falls, such as assisting them to mobilise and observing them in their room regularly. However we were not assured staff had clear directions and information on how to support this person in a way which ensured their specific needs were met.

Most relatives told us their loved ones appeared to be settled in the home and their needs were met by staff who were patient and kind with them. However one relative told us how they had repeatedly told staff their loved one did not like a particular food and this continued to be given to them. The care plans for this person did not identify this preference. Staff were not aware of this preference.

Activities were not always aligned with people's preferences. Whilst assessments had been completed for most people who lived on the Rosemead Unit as to their previous hobbies, likes and dislikes, there was no evidence to show these had been taken into account in the planning of activities for people. Most relatives told us their loved ones did not appear to have any specific interests anymore, but that staff did their best to involve them in chatter and interactions. One relative told us, "Unfortunately they all have dementia and I think that means they just get forgotten. Its not right and they often just sit in the lounge area doing nothing. " We observed a session of music and interaction within the dayroom area of the Rosemead Unit. Whilst one person was very actively involved in this session, others appeared less interested and did not participate. There were no individualised plans of activities to meet the needs of people who lived with dementia. This meant we could not be assured people received care and support which met their needs promoting their preferences and choices.

Communication with people who lived on the Rosemead Unit was noted to be very difficult at times, with many people requiring support to express their feelings or feel reassured they were safe. Care plans lacked detailed information about people's needs for communication and often made judgemental statements about people's moods and behaviours. Statements such as " Sometimes [person] can not be orientated to time and place", and , "Verbal communications and through expressions", gave no information for staff on how to meet the communication needs of people and support them in communicating with others. Statements such as "[Person] is unable to socialise meaningfully with other people," gave staff no information on how to support the person in interacting with others and allowing them to participate in activities as they wished. We saw several people who communicated verbally in a way which staff could not understand. Whilst staff were patient in listening to people they appeared to view that the conversation was meaningless and the person did not require any support. For staff working on the Rosemead Unit we observed their spoken English communication skills were limited. This meant we could not be assured people were always supported to communicate their needs in an effective way. Care plans in place did not support effective communication with people who have complex needs.

Care records lacked effective, consistent information to ensure staff had the appropriate information to meet people's needs. For one person, who had recently been

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Is the service responsive?

bereaved, records were not consistent in the approach staff should use to support this person. We asked the registered manager how this was being addressed and they told us, "[They] become very distressed about [the person's death] and so we don't talk about it with [them]." Records did not reflect this and held conflicting information on how this person should be supported. For another person, care records were inconsistent in the support they required with eating and drinking; one record identified they should have mashed food and another record identified a normal diet. There was no order to care records to allow staff to effectively access the information they required and daily records were not aligned to the plans of care people should be receiving. This meant we could not be assured complete and contemporaneous records were held for people. A lack of clear and concise records which identified people's specific needs meant we could not be sure their specific needs had been identified or were met.

The provider had sought external advice on the environmental setting of the Rosemead Unit and how this could be adapted to meet the needs of people who lived with dementia. Significant works had been carried out to provide a stimulating and suitable environment for people. Memory boxes, clear signage and bold colours on doors and toilet areas supported the needs of some people who lived with dementia. We were told by staff people had not been given the opportunity to be involved in the choice of decoration for the unit . People's views and choices had not been respected.

Care staff responded to people's needs in a calm, kind and effective way. However they told us this was because they had received training on working with people who lived with dementia. They did not access care plans or know whether these provided any clear information about the care they were to provide. They told us they relied on each other and their knowledge of people to care for them. Registered nurses told us all the care a person would require would be in their care plans and this was provided for all staff to review. There was a clear lack of understanding as to the purpose of individualised care plans for people.

The above concerns identified significant shortfalls in the provision of person centred care and are a s breach of Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014

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Is the service well-led?

Our findings

In our inspection on 5 January 2015 we found a lack of recording, reporting and learning from incidents and accidents and the ineffectiveness of audits completed was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We issued a warning notice to the provider and registered manager requiring them to be compliant with this Regulation by 12 April 2014.

At this inspection we found that whilst some attempts had been made to address the concerns we had identified, the warning notice had not been fully addressed.

We found staff had a poor understanding of the need for individualised care plans and there was a lack of management provided by the registered manager to ensure staff understood and completed this responsibility. Minutes from staff meetings in February and March 2015 showed the registered manager had spoken with staff about the outcome of the CQC inspection of January 2015. The minutes stated, “There were serious concerns about Rosemead.” The registered manager had provided information for registered nurses on how to ensure care plans were person centred and fully informed by risk assessments; however this had not been completed and the registered manager had not followed this up. Following our inspection the registered manager advised us all staff had been made aware of the action plan, dated 19 March 2015.

Care records had not been audited in a way which ensured they contained all information required for staff to deliver a safe and effective service. The registered provider had a system in place called ' Resident of the Day' which had been adapted to ensure all care records were reviewed and updated each month. This system was ineffective and staff had not identified the concerns with care records which we had. Care records were inconsistent, lacked detail and individualised care plans. This had not been identified and addressed in all care plans. The registered manager had failed to ensure a system was in place where people’s care needs were assessed, monitored and updated in line with their needs and wishes.

Incidents and accidents were reported to the registered manager through the completion of an incident/accident form by staff. The registered manager told us they reviewed these daily to check for any incidents of concern or patterns of incidents. The registered manager provided a copy of all the reports completed to date on falls which had occurred in the home between August 2014 and January 2015. We saw there was a significant increase in the number of falls reported in January 2015; from 19 falls in December 2014 to 32 falls in January 2015. No figures were available for February or March 2015. We asked the registered manager if they had identified why there had been an increase in the number of falls; however they were unable to tell us. They were unable to confirm the number of falls in February or March 2015. This meant we could not be assured incidents and accidents were being monitored effectively and appropriate actions taken to ensure the safety and welfare of people.

Incident and accident forms were not always completed in the event of injury to a person. Care records held information relating to injuries people had received, such as bruising or a skin tear; however there was no corresponding information to identify how this had been investigated to prevent a recurrence.

Incident investigation forms held incorrect information , and actions identified to take to reduce the possibility of recurrence were not completed. For one person who had reportedly fallen 13 times between December 2014 and April 2015, the registered manager’s report into their falls stated, “Whilst in bed [they] use bed rails and has not fallen from [their] bed.” However the incident reports for this person showed they had climbed over the bed rails on one occasion and on another were found on the floor after getting out of bed when the bed rails were in place. The report states, "bed rails are removed from this person’s bed once they are awake”. We noted these were in place at all times when this person was in bed, including when they were awake. Care records showed the bed rails were to be used at all times when they were in bed. There was inconsistency between the registered manager’s report , the care plan in place and our observations of the care this person received. Incidents and accidents were not reviewed effectively to ensure appropriate actions were put in place to ensure the safety and welfare of people.

The provider’s policy, ‘Accident /Incident Reporting Policy and Procedure’, dated 1 December 2014 gave no

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Is the service well-led?

information or guidance about their expectations of staff to monitor the themes or recurrence of incidents and accidents and report on the effectiveness of actions taken to reduce the risks of them recurring. Processes were not in place to assess, monitor and mitigate the risks associated with incidents and accidents in the service relating to the health, safety and welfare of people.

Concerns identified at this inspection had been discussed and reported on at two previous inspections with the registered manager and provider. They had not taken appropriate actions to address these concerns. An action plan to address the concerns we had raised in relation to person centred care and the monitoring and audit of care plans and incidents and accidents had not been completed in a timely way.

The above concerns identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not designed with a view of achieving the service users preferences and meeting their needs. Regulation 9 (1)(3) (b)

The enforcement action we took:
A condition has been placed on the provider's registration to prevent admissions to this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, or to improve the quality and safety of the services provided. Regulation 17 ((1)(2)(a)(b)(c)

The enforcement action we took:
A condition has been placed on the registered provider's registration to prevent admissions to this service