Care Quality Commission

Summerfield Medical Limited

Summerfield Nursing Unit

Inspection report

58 Whittington Road
Cheltenham
Gloucestershire
GL51 6BL
Tel: 01242259260
Website: www.summerfieldnursing.co.uk

Date of inspection visit: 25 March 2015
Date of publication: 29/04/2015

Ratings

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

Overall summary

At an inspection of this service in November 2014 we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action with five of the breaches and issued a warning notice for one other breach, stating they must take action.

We undertook this focussed inspection on 25 March 2015 to follow up on the warning notice and to check if the provider had made improvements to the care and welfare of people. 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.

At this inspection we found the support and care provided was not responsive to some people's care needs. Some people still remained at risk because their care records still did not give staff the specific guidance required to meet people's needs. Information was held in both electronic and paper form. However not all staff were able to access electronic records and so had to rely on verbal handover from paper records. Paper records did not always give enough information about people's needs.

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 responsive?
The service was not responsive to people's needs.

Staff were not always responsive to people's individual care needs. People's care records did not reflect their care and support needs.

Inadequate

Care Quality Commission

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 25 March 2015. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 21 and 24 November 2014 had been made. The team inspected the service against one of the five questions we ask about services: 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 one person using the service, two nurses and one agency nurse as well as the management team. We carried out a tour of the premises and reviewed the records of four people using the service.

Inadequate

Is the service responsive?

Our findings

At our inspection of 21 and 24 November 2014, we found some people's care records were inconsistent and did not give staff the guidance they required to support and deliver care for people. At this inspection although there were some improvements we found people's care records still did not give staff the specific guidance required to meet people's needs.

One person needed to be repositioned regularly as part of their pressure area care management. Their risk assessment lacked any detail around this care only stating "Introduce repositioning according to (the person's) needs". There was further information recorded about the frequency of these turns indicating they should be turned "3-4 hourly" or "3 hourly". However there was no recorded rationale for why this frequency of turning had been implemented.

This person was being given a soft diet. This had been determined by the service without consultation with the appropriate specialist. Staff told us they had experienced delays with referrals to the speech and language service and had therefore not made a referral for this person.

The home was using a combination of electronic and paper care records. Certain paper records were available to care staff and agency nurses in the form of "Activities of Daily Living (ADL)" documents. However the ADL documents did not always contain the necessary information for the care of people. For example one person's record did not state they were diabetic or that they had wounds that required dressing. Information about how to manage the person's diabetes was on a document faxed from the person's GP practice and was held with the medication administration records instead. However this information was not up to date because it did not correspond with the current medication the person was taking.

Staff told us information about a person such as if they were diabetic, on a soft diet or had wounds was shared with staff at shift handover. Failing this staff, would be able to deliver the appropriate care by referring to their prescribed medicine charts such as prescribed dressings or thickeners for soft diets.

Another member of staff told us they would know what wound dressings a person would require from their own experience. They also told us they would know if a person was on a soft diet because the kitchen would know this and send the right meals.

Further examples of a lack of guidance for staff to deliver care include one person who had their weight recorded due to weight loss. There was no plan in place for staff to follow and no evidence that any action had been taken to address this person's weight loss. Another person had a "wound assessment and treatment plan" in place. However this was a log of wound care given and not a specific plan for staff to follow. There was no information for staff regarding when dressings required changing. Records showed changes of wound dressings had been carried out at irregular intervals.

Twice daily checks were now in place for pressure mattress settings. In order for people to receive the best level of support and benefit from a pressure mattress they must be maintained at the correct setting. Records showed pressure mattress settings had been maintained at the correct level. On one occasion a mattress had been found incorrectly set. Remedial action had been taken and recorded to return the mattress to the correct setting for the person.

Fluid input and output had been recorded for people with twice daily balance totals. This was to enable intervention to take place in a timely fashion if an issue with fluid intake or output was discovered.

We found that the registered person had not protected people against the risk of receiving care that was inappropriate or unsafe. This is a breach of 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.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.** **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care.**