Hexon Limited

Summer Court

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 16 September 2015 and was unannounced. We previously visited the service on 18 June 2014 and we found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for up to 37 older people, some of whom may be living with dementia. The home is registered to provide personal care and nursing care. On the day of the inspection there were 20 people living at the home. The home is located in Hornsea, a seaside town in the East Riding of Yorkshire. It is close to town centre amenities and is on good transport routes.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was not registered with the Care Quality Commission (CQC), although they were in the process of submitting their application. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People told us that they felt safe living at Summer Court and we saw that the premises had been maintained in a safe condition.

We found that people were protected from the risk of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

The manager and some staff had completed training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). There was clear information available to staff in the manager's office on the principles of the MCA and DoLS and staff were able to explain these principles to us. People were supported to make their own decisions when they had capacity to do so, and best interest meetings were held when people did not have the capacity to make decisions for themselves.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. The manager told us that a new induction programme was being introduced by the organisation and this would result in more robust induction training for staff. The training records evidenced that most staff had completed training that was considered to be essential by the home and that most staff had achieved a National Vocational Qualification (NVQ).

New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with older people had been employed. We saw that there were sufficient numbers of staff on duty to meet people's individual needs. People told us that staff were caring and we observed that staff had a caring and supportive attitude towards people.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust. Staff who had responsibility for the administration of medication had completed appropriate training.

People told us they were happy with the meals provided by the home. We saw that people's nutritional needs had been assessed and that their special diets were catered for. We saw there was a choice available at each mealtime. More care needed to be taken to ensure people received one to one support with eating and drinking.

There were systems in place to seek feedback from people who lived at the home and relatives / visitors. Feedback had been analysed to identify any improvements that needed to be made. There had been no formal complaints made to the home during the previous twelve months but there were systems in place to manage complaints if they had been received.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the manager were designed to identify any areas that needed to improve in respect of safety and people's care. We saw that, on occasions, incidents that had occurred at the home had been used as a learning opportunity for staff.

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?
The service is safe.

Good

Staff had received training on safeguarding adults from abuse and moving and handling, and we saw safe moving and handling techniques being carried out on the day of the inspection.

We saw that staff had been recruited safely and that sufficient numbers of staff were employed to meet the needs of people who lived at the home.

There were robust medication systems in place. Accidents or incidents were monitored to identify any improvements in practice that might be needed.

Is the service effective?
The service is effective.

Good

We found the provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff undertook training that equipped them with the skills they needed to carry out their roles. This included both induction and refresher training.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home. People told us they had access to health care professionals when required.

Is the service caring?
The service is caring.

Good

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff on the day of the inspection.

We saw that people's privacy and dignity was respected by staff. People's individual care needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

Is the service responsive?
The service is responsive to people's needs.

Good

People's preferences and wishes for their care were recorded. Care plans recorded information about their previous lifestyle and the people who were important to them and this helped staff to provide person-centred care.

People were able to take part in their chosen activities and their visitors were made welcome at the home.

There was a complaints procedure in place and people were confident that any complaints received by the home would be dealt with in a professional manner.

Summary of findings

Is the service well-led?

Good

The service is well-led.

The manager was not registered with the Care Quality Commission as required. However, people told us the home was well managed and that the manager in post promoted a positive and open atmosphere within the home.

There were sufficient opportunities for people to express their views about the quality of the service being provided.

Quality audits were being carried out to monitor that the systems in place were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

Summer Court

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.

The inspection took place on 16 September 2015 and was unannounced. The inspection team consisted of an adult social care (ASC) inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the registered provider and information from health and social care professionals. We did not ask the registered provider to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with five people who lived at the home as well as one relative and one friend of a person using the service. We also spoke two members of staff, a visiting health care professional, the manager and the general manager.

We observed the serving of lunch and looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with five people who lived at Summer Court and they all told us they felt safe living at the home. One person said, "Yes, always somebody about and I have a call button at night" and another said, "All the people here make me feel safe." A relative also told us, "I think she is safe – there is always somebody about."

We asked staff how they kept people safe and they described the equipment they used, the training they had and health and safety considerations. One member of staff said, "We use lap belts on wheelchairs, bed rails and bumpers and keep our eyes open for trip hazards" and another told us, "We make sure they are wearing sensible shoes, are seated comfortably at dining tables and that they have footplates on their wheelchair." We observed staff assisting people to transfer from chairs to wheelchairs and noted that this was done safely and using the correct equipment.

Risks associated with a person's care had been assessed and were recorded in their care plan. People had risk assessments in respect of showering and bathing, manual handling, nutrition, the risk of falls, hot substances, bed rails and bumpers, use of the call bell and tissue viability. Risk assessments recorded how risks could be reduced and managed by staff.

We spoke with the local authority safeguarding adult's team prior to the inspection and they told us they did not have any concerns about this service. Records evidenced that not all staff had completed training on safeguarding adults from abuse. However, the staff who we spoke with were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the manager, or to the head office if needed. Staff also told us that they would not hesitate to use the home's whistle blowing policy if they were concerned about any incidents or care practices at the home, and they thought the manager would deal with any issues professionally and confidentially.

One member of staff described how they would support someone who occasionally became agitated or anxious. They said, "We talk to them – calm them down. We go for a walk with them and make them a cup of tea." We were told that information to advise staff on how to effectively manage a person's anxious behaviour was recorded in care plans so all staff knew what action to take to keep people safe and avoid the use of restraint. A member of staff told us, "We don't use restraint; we comfort people and calm them down."

We checked the recruitment records for two new members of staff. We saw that prospective employees submitted an application form that included their employment history, the names of two employment referees, details of their skills, knowledge and experience and a declaration about any criminal convictions. We saw that documents confirming the person's identity, employment references and a Disclosure and Barring Service (DBS) check had been obtained by the registered provider. The DBS service maintains a register of people who have been referred to them because they are considered unsuitable to work with vulnerable groups of people. Although we found that one person only had one written reference in place, the manager acknowledged this was an oversight and assured us that a second reference would be obtained. There was a system in place for checking that nurses were appropriately registered with the Nursing and Midwifery Council (NMC); nurses have to be registered with the NMC to practice as a nurse. This evidenced that only people considered suitable to work with vulnerable people had been employed.

Staff told us that they shadowed an experienced care worker as part of their induction training and that this helped them to understand their new role. New staff received a copy of their job description and the organisation's employee handbook; this ensured they were clear about the role for which they had been employed.

We saw that dependency scores were recorded for people although these did not indicate whether the person's score meant they had high, medium or low dependency needs. Dependency scores are normally used to assist the service to determine staffing levels, but at Summer Court they were not being used for this purpose; the manager and general manager told us that this document would either be amended so it was fit for purpose or not used at all.

The manager told us there was a nurse on duty each day shift and night shift; shifts were 8.00 am to 8.00 pm or 8.00 pm to 8.00 am. There were three care staff on a day shift plus one care worker from 8.00 am to 2.00 pm. We saw that this number of staff were on duty on the day of the inspection. The manager was on duty in addition to nurses and care staff and we saw that the times of her shift varied from day to day, but were recorded on the staff rota.

Good

Is the service safe?

Ancillary staff were employed in addition to care staff; there was a cook and one or two domestic staff on duty each day. This meant that nursing and care staff spent most of the day supporting people who lived at the home.

Staff told us that four people at the home needed the support of two care staff to assist them with personal care and transfers so they needed four staff on duty each morning. They told us that these staffing levels were usually maintained. This meant that there were enough members of staff on duty to meet the needs of the people who lived at the home.

On the day of the inspection we saw that call bells were responded to promptly and people who lived at the home confirmed this. One person told us, "Always seem to be somebody about, my call button is usually answered within 5 minutes." Staff told us that there were usually enough staff on duty and that every effort was made to cover shifts for any staff who were off sick or on annual leave. However, one visitor said their relative had mentioned that on occasions they had requested a drink and one had not been provided.

People who lived at the home had personal emergency evacuation plans (PEEPs) in place. There was also a contingency plan in place that advised staff how to deal with unexpected emergencies, such as power failures and adverse weather conditions.

There were service certificates in place for the maintenance of the passenger lift, mobility hoists and slings, the electrical installation, portable appliances, the fire alarm system and fire extinguishers to ensure that the home remained safe for the people who lived and worked there. In addition to this, day to day maintenance and safety checks were carried out by the home's handyman, including checks on the call bells. We saw that a maintenance record for hoists used in the home recorded that one hoist should not be used. The manager assured us that this was no longer in use.

We noted that visitors to the home were not signing in or out of the visitor's book. We discussed with the manager how this could be a problem in the event of a fire. The manager told us that people were asked to sign their name in the visitor's book and we saw a sign in the entrance hall asking people to do this. The manager told us that she would ensure that people who entered the home were reminded to use the visitor's book.

We saw the monthly accident audit. Any accidents that had occurred during the month were recorded and we saw they included details of the person concerned, the type of accident or incident, where the accident had occurred and any injuries incurred. Records evidenced that appropriate referrals had been made to health care professionals, including the falls team, when people had been having regular falls or accidents.

We noted there was a stair gate at the bottom of the stairs but not at the top. We discussed this with the manager at the end of the day and she told us that people who were mobile used the passenger lift and not the stairs. There were two people with bedrooms on the first floor who were independently mobile and risk assessments had evidenced the stairs did not pose a risk to either of them.

Some people had bedrail and bumper monitoring forms in place and other people had pressure relieving charts in place. We noted some forms had not been completed consistently. We raised this with the manager on the day of the inspection and she told us that some were placed in bedrooms where people no longer needed them and that is why they had not been filled in. She acknowledged that these needed to be removed from the bedrooms and agreed to do so that day.

People who lived at the home told us they received their medication on time. We observed the administration of medication and saw that this was carried out safely; the manager (also the nurse on shift) did not sign medication administration record (MAR) charts until they had seen people take their medication, and people were provided with a drink of water so that they could swallow their tablets or medicine. There was a protocol in place for the administration of 'as and when required' (PRN) medication.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Blister packs were colour coded to identify the time of day the tablets needed to be administered and the same colour coding was used on MAR charts; this reduced the risk of errors occurring.

Blister packs were stored in the medication trolley, which was locked and stored in the medication room when not in

Good

Is the service safe?

use. The medication fridge was also stored in the medication room and we saw that the temperature of the fridge and room was checked and recorded each day to ensure medication was stored at the correct temperature.

There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. Controlled drugs are medicines that require specific storage and recording arrangements. There was a note on the CD cupboard door as a reminder that two staff needed to sign both the CD book and the MAR chart when CD's had been administered. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cupboard balanced. We also saw that CD's were audited each week to ensure no recording or administration errors had been made.

We checked recording on MAR charts and found this to be satisfactory. There were minimal gaps in recording and two staff had signed hand written entries to reduce the risk of errors occurring. When medication had been stopped by a health care professional this had been recorded on the person's MAR chart. These records would be improved if the date the instruction had been received and the name of the health care professional were recorded so that this information could be cross referenced with information in the person's care plan. There were specific instructions for medicines that needed to be administered weekly, or by a district nurse and for people who had been prescribed Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered.

One person administered their own medication and there was an appropriate risk assessment in place to evidence that safety aspects of this had been considered and managed.

There was an effective stock control system in place and we saw that all medication not in blister packs had the date of opening recorded on the packaging to ensure they were not used for longer than the recommended period of time. The arrangements in place for medication to be disposed of were satisfactory.

There was a medication policy in place that included clear information for staff on safe ways of administering, storing, ordering and recording medication. There was also a homely remedy medication policy. There was a separate cabinet for the storage of homely remedies as well as a separate record book. Only the nurses employed at the home had responsibility for the administration of medication, and we saw that competency checks were carried out to ensure they retained the skills and knowledge needed to carry out this task.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

Training records evidenced that ten staff had attended training on MCA and three staff had attended training on DoLS. In addition to this, we saw that there was clear information displayed in the manager's office to inform staff about the principles of the MCA. The manager and staff who we spoke with were aware of the principles of MCA and DoLS, how they impacted on people who used the service and how they were used to keep people safe.

We saw that one person's care plan recorded, "A DoLS order has been considered for (the person) coming into our care home and the following decision has been made – a DoLS is not required." This record had been signed by the person concerned and the nurse who had carried out the person's care needs assessment. The manager told us that they were gradually submitting DoLS applications to the local authority for consideration, usually two or three at a time.

The MCA legislation is designed to ensure that, when a person does not have capacity to make important decisions, any decisions made on their behalf are made in their best interests. We saw that a person's capacity had been assessed and their ability to make decisions considered in each area of their care plan. There was evidence that best interest meetings had been held to assist people with decision making.

We saw in care plans that people had been asked to sign a document to record their consent to staff administering their medication, taking photographs for their personal and medication records and sharing information with health and social care professionals. People told us that they were consulted about their care and that staff asked for their consent before assisting them with personal care and other tasks. One person told us, "Nobody tells me what to do, I am in charge" and another person said, "They ask me what I want to wear."

Staff had attended training on dementia awareness; this was considered to be essential training by the manager. We also noted that there was information displayed in the manager's office that provided advice about dementia and evidence based support. We asked people if the signage that was in place to help them find their way around the home was sufficient. All of the people who we spoke with told us that they could locate bathrooms, toilets or their bedroom, and we observed that people who could mobilise independently went to and from their rooms during the day. However, although some bedrooms had numbers on them and a small number had people's names displayed, there was minimal signage to assist people with orientation around the home. The manager told us that she had ordered more suitable signs for toilets and bathrooms and that these would be put in place when the redecoration was complete. The manager understood that people with cognitive difficulties might not recognise current photographs of themselves, so they were considering using memory boxes rather than photographs to help people locate their rooms. Memory boxes contain items that people associate with their own life. She also told us that new flooring was being provided; this would be plain to assist people with cognitive difficulties to walk around the home more easily.

People who lived at the home told us that staff seemed to have the skills they needed to carry out their role. One person told us, "Mostly, they are very good." Two relatives told us, "From what I have seen, yes" and "I think so – always seem obliging."

We saw the induction records for two members of staff. We noted that these were brief and consisted of an orientation to the home rather than specific training. The manager told us that the organisation were in the process of developing a new induction programme that would be adopted by all care homes in the group. This would include new staff completing the Care Certificate; the Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Staff told us they had induction training when they were new in post and that this included shadowing experienced care workers. Some long term staff told us that their induction training had been brief, but that it was more thorough for new staff. Each member of staff had an individual training record in place that recorded the training they had completed at previous work places and at Summer Court.

The manager told us that they considered essential training to include moving and handling, fire safety, health and

Good

Is the service effective?

safety, safeguarding vulnerable adults from abuse, dementia awareness, infection control, food hygiene and first aid. The training records we saw evidenced that most staff had completed this training, although there were some gaps. In addition to mandatory training, some staff had attended training on end of life care, communication, falls, behaviour that challenges the service and mental health awareness. Staff confirmed that they had attended refresher training on various topics during the previous year. One person told us they were working towards a National Vocational Qualification (NVQ) Level 3 in Health and Social Care and we saw that most staff at the home had achieved this award at Level 2 or 3.

The quality assurance folder contained evidence of staff appraisals that had been carried out in January 2015. The manager acknowledged that staff supervision meetings had not been held as often as they would like. Group supervision meetings had been held in May and August until they were 'back on track' with one to one supervision meetings. We saw these records on the day of the inspection. Staff told us they felt well supported by the manager; one person told us, "I can talk to the manager any time."

People who lived at the home told us that they had good access to GPs and other health care professionals. One person told us, "I can see a doctor and I saw a physio this morning" and another said, "Yes, one comes here if you need one." We saw a list on display that indicated a chiropodist visited the home each month. Visitors told us that they were kept informed of any changes to their relative's health and well-being.

Health care professionals told us that there was good communication between themselves and staff who worked at the home. They said that staff asked for advice appropriately and they listened to that advice. There was a record of any contact people had with health care professionals; this included the date, the reason for the contact and the outcome, plus a record of any advice given. We noted that on occasions these entries were made by the health care professional rather than a member of staff. We saw records of appointments and contacts with GP's, district nurses, dieticians and speech and language therapists (SALT). We noted that advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records.

In the quality assurance folder we saw documents that recorded monthly observations for each person who lived at the home. This included the date, the person's weight and their blood pressure. This enabled the manager to have oversight of each person's general health.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that one person had a 'Do Not Attempt Resuscitation' (DNAR) form in place and this had not been recorded in their patient passport; the manager agreed that this should be included and told us they would update the patient passport.

We observed the lunchtime experience and saw that the meal served looked appetising and hot, and people appeared to enjoy it. We saw that some people required assistance with eating their meal and although this was offered, staff did not stay with one person to ensure they ate their meal. This was not conducive to encouraging good nutritional intake. We discussed this with the manager at the end of the inspection and she acknowledged that this had occurred and told us she would ensure this practice ceased, as staff knew they were expected to stay with one person to assist them with their meal. Three people were provided with a clothes protector to maintain their dignity. We noted that one person had to wait a long time to be assisted to leave the table at lunch time.

We saw that a choice of drinks were offered to people at lunchtime and that drinks were available throughout the day. There was a choice of two main meals at lunchtime; we saw the cook offer these choices to each person in the dining room. However, there was no written menu or picture menu on display; picture menus assist people with cognitive difficulties to choose their own meal.

The cook told us that there was a board in the kitchen recording any special diets that people required, and their likes and dislikes. We also saw that people's specific nutritional needs had been recorded in patient passports so that this information could be shared with hospital staff if needed.

Good

Is the service effective?

People told us they liked the meals provided at the home and that staff were aware of their nutritional needs and their likes and dislikes. Comments included, “Food is good, cooked nice, good choice” and “It is good, it is varied. I have cereal for breakfast, a hot meal for lunch. Tea-time is good – we get sandwiches.” However, one person mentioned the menu was repetitive and another said, “Some days are better than others.”

When nutrition had been identified as an area of concern, we saw that appropriate referrals had been made to health care professionals, and that their advice had been incorporated into care plans. We saw a sample of charts that were used to monitor people’s food and fluid intake, and noted that these were being completed consistently. People were also weighed as part of nutritional screening. This ensured people’s nutritional intake could be monitored to promote optimum health.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the Local Authority environmental health department. The inspection checked hygiene standards and food safety in the home’s kitchen. Five is the highest score available.

Good

Is the service caring?

Our findings

People who lived at the home told us that staff cared about them and that they felt the care was centred on them. One person told us, "Yes, there are a few friendly faces" and another said, "As much as they can, yes they do, couldn't wish for better staff." One person raised an issue with us about a specific member of staff and we discussed this with the manager at the end of the inspection. The manager was aware of this issue and explained to us how it had been resolved.

Staff told us that they felt all staff who worked at the home genuinely cared about the people who they were supporting. They said, "It's like one big happy family" and told us about a person who had recently returned to the home after a stay in hospital. They had said, "I'm back home now." Relatives told us that they felt staff really cared about the people they supported, and a health care professional told us, "Staff genuinely care"

On the day of the inspection we observed positive interactions between people who lived at the home, visitors and staff. Staff told us that they read people's care plans and that these included information that helped them to get to know the person, such as their family relationships, their hobbies and interests and their individual likes and dislikes. Staff told us that they had time to spend with people and they got to know about people's individual needs by reading the care plan and spending one to one time with them.

People told us that staff communicated with them and shared information in a way they understood. Comments included, "They chat to me alright" and "If you ask a question they will do their best to answer it." When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

There were systems in place to ensure information was shared, including meetings with people who lived at the home and their relatives. We asked people if they were kept informed about what was happening in the home. One person said, "They tell us when the entertainers are coming" and another told us they had been kept informed about the redecoration programme. They said, "They have made a fantastic job of the place – every room has been painted."

On the day of the inspection we saw that people were encouraged to be as independent as possible. Care plans recorded what people could do for themselves and what they needed assistance with. Staff told us that they supported people to do as much as they could for themselves. One member of staff said that they asked people to help them with chores, such as folding laundry. They told us, "Otherwise they lose their ability."

We noted that people who lived at the home were well presented, appropriately dressed and wearing suitable footwear. They were wearing a style of clothing that they had chosen themselves and that allowed them to express their personality. People's individual lifestyle choices and family relationships were understood and respected by staff.

People told us that staff respected their privacy and dignity and said that they always knocked on doors before entering their room. Staff described how they protected a person's privacy, such as making sure the curtains were closed, covering people during personal care and offering to let people wash themselves if they could. We saw that one ground floor bathroom did not have a curtain or blind. The manager told us that a roller blind was due to be fitted to this window.

The manager and previous managers had carried out an assessment on each member of staff to look at their skills around privacy, dignity and respect whilst carrying out their work role. Staff completed a self-assessment as part of this process, and these assessments were carried out each year. This gave the manager the opportunity to discuss each person's skills and each person's areas for improvement.

The manager told us that they were able to access advocacy services for people who lived at the home via Age Concern or the Alzheimer's Society if they were needed. There was information about Healthwatch displayed on the notice board in the entrance of the home. Healthwatch is the independent consumer champion for health and social care in England.

Good

Is the service responsive?

Our findings

We asked people if they had been involved in developing their care plans and none of them seemed certain about this, although one person said they thought they had been involved in care plan reviews. A visitor told us that their relative had attended a meeting with Social Services staff and staff from the home when they were newly admitted to discuss their care needs. However, we saw that care plans included information that had been gathered from the person and / or their relatives at the time of their admission.

We saw that each person had a care needs assessment, a care plan and appropriate risk assessments in place. They covered topics such as communication, personal hygiene, physical health, continence, tissue viability, diet and nutrition, mental capacity and medication. We noted that care plans and risk assessments were reviewed in-house each month and those we saw had been updated appropriately. This meant that staff had up to date information to follow about the people who they were supporting.

Staff told us that they encouraged people to make choices, such as where to eat their meals, where to spend the day, what activities to take part in and what to wear. One staff member told us, "I hold clothes up and get them to choose if they are not sure" and another member of staff told us they suggested various activities if people could not decide how to spend their day.

A room that was previously a dining room was in the process of being redecorated. The manager told us that this was to become a day room where activities could be held and where 'special' Sunday lunches would be served. They planned that a different group of people would use this room each Sunday to have a special meal with wine, and that these people would stay in the dining room after lunch to take part in activities.

Staff told us that communication at the home was good, and this was supported by a health care professional and visitors who we spoke with. Staff said that they had 'handover' meetings from shift to shift to ensure all staff were aware of people's up to date care needs. The manager told us that, when people had been absent for a few days, she met with them to ensure they were up to date with people's current health needs.

People told us about available activities. One person said, "We have a lady that comes in once a month and she sings" but other people said that their entertainment was mainly watching the TV. The manager told us that activities normally took place each day but on the day of the inspection a member of staff had accompanied someone to the hospital at short notice so they were one staff member 'down' during the afternoon. This meant that, on the day of the inspection, no activities took place. However, we saw that staff spent time talking to people, that some people had visitors and that people were encouraged to go for a walk, read, listen to music and watch TV.

Staff told us that a male who lived at the home enjoyed gardening, and a greenhouse and shed had been bought for him. Another person liked knitting and colouring and some people received a newspaper or magazine each week. They told us that several people enjoyed quizzes and playing bingo.

The manager acknowledged that staff were not good at recording activities. She said that a 'motivation' class was held every two weeks and a singer attended the home every two weeks, and that activities took place between three to six days a week. We saw records for group activities and these included food tasting, colouring, bingo and quizzes. The manager said that staff were now encouraged to record information in each person's care plan about activities they had taken part in, so records should improve.

Everyone who lived at the home told us that their family and friends were made welcome, and we saw visitors in the home on the day of the inspection.

We noted that one person told staff they wanted to leave the table at lunch time and they had to wait a long time for assistance. Although we appreciated that staff were busy helping people to eat their meal, on this occasion this person did not have their individual needs met.

People who lived at the home told us that they would not hesitate to make a complaint. Comments included, "I'd certainly tell the carers – can't think of anything", "I would go and see the boss. I do see her – we are good friends" and "I would tell the manager but I've never had to." Visitors told us they would feel comfortable in raising concerns. One person said, "I would see the manager – she seems

Good

Is the service responsive?

very approachable." A health care professional who we spoke with told us they had never heard any complaints about the home, and that they were confident the manager would deal professionally with any concerns raised.

Staff told us they would support people to make a complaint if they were reluctant to do so. They said they would "Try to get to the bottom of things" and "Try to put things right."

We saw that the complaints procedure was displayed in the entrance area of the home. We checked the complaints log and saw that there were forms ready for people to complete should they wish to raise a complaint. However, no complaints had been received by the home during the previous twelve months.

Good

Is the service well-led?

Our findings

The manager was not registered with the Care Quality Commission as required. However, on the day of the inspection they told us that they would be applying for registration. We saw that the manager submitted notifications to the Care Quality Commission as required. These are forms which enable the registered manager to tell us about certain events, changes or incidents that have occurred in the home. People told us the home was well managed and that the manager in post promoted a positive and open atmosphere within the home.

We asked staff about the culture of the home; they told us that there were good team dynamics, a fairly consistent staff group, that staff were very 'open' and that "Everyone gets along – staff and residents – we are equals." They said they could raise issues with their colleagues and these would be well received and dealt with. They also told us that the manager was approachable and "Listens to our point of view and is very fair."

We asked visitors to describe the culture of the home and they told us, "I have never had to speak to the manager but I feel I could – she seems good at her job." We also received positive feedback from other people. A health care professional told us that they knew some of the staff as they had previously worked at other care homes in the area. They said staff had told them they "Loved working at Summer Court." They also told us that the manager was approachable and "Always around the home." People who lived at the home told us they were able to talk to the manager. One person said, "I know where the manager's office is – I do know her."

There were no reward schemes for staff although senior care workers received a slight salary increase. This meant there was an incentive for people to gain more knowledge and skills, and be promoted within the organisation.

The training matrix was not completely up to date and the manager sent us an updated version after the inspection. Apart from the training record, when we asked the manager if we could review documents in respect of people's care and welfare and the management of the home, they were found quickly and were seen to be in good order. The daily records we looked at for people who lived at the home had been reviewed and contained appropriate information. This meant that we had no concerns about record keeping at the home.

There was a quality assurance calendar in use and this recorded the quality audits, quality surveys, meetings and staff appraisals that were planned for the year, as well as those that had already taken place. For example, staff meetings had taken place in February, May and August and another one was planned for November 2015. An action plan had been developed following the meeting in August 2015; this stated that improvements needed to be made to the cleanliness of the toilets and redecoration of the home. The action plan recorded updates when actions had been achieved, and on the day of the inspection we saw that redecoration of the home had commenced. Surveys for people who lived at the home had been carried out in March and August and another one was planned for October 2015.

The visitors we spoke with were not aware of any 'resident' or relative meetings. However, we saw a notice advertising these meetings in May, July, September and November 2015. The minutes of the meeting in July 2015 recorded that people had been asked how they would like the money raised via fundraising to be spent. People had suggested purchasing vending machines and helping towards the cost of redecoration. People had also asked if they could play more games of bingo. We saw that these minutes were displayed on the notice board in the entrance hall. The minutes of the meeting in May 2015 evidenced that ten people who lived at the home and three relatives had attended. They had discussed staffing levels, activities and having meals in a 'quiet' room; on the day of this inspection we saw that this was in the process of being actioned.

In addition to this we saw the copy of a quality survey that had been sent to relatives in December 2014. Nine surveys had been returned and we saw that most responses were positive. One relative recorded, "As a family we are very happy with the care and affection shown to my mother." An action plan had been developed when the responses had been analysed, with completion dates of January 2015 and Summer 2015 (this was in relation to improvements to the outside of the premises). This showed us that the service was gathering feedback and using this is to drive improvements.

Good

Is the service well-led?

Staff meetings were held and staff told us that they felt able to express their views at these meetings, and that these were listened to. The minutes of one meeting recorded that staff had been given feedback about the meeting that had been held with people who lived at the home and relatives the previous day. This evidenced that peoples' views were listened to and shared with staff appropriately. Other topics discussed included activities and recording of activities, infection control, staff champions, staff training and maintenance of the premises.

Audits on accidents, window opening restrictors, first aid boxes, and people with pressure areas were carried out each month. The audit on window opening restrictors identified that four windows were not fully protected. The manager told us that all of the restrictors had been replaced; we checked a sample and saw that they were working correctly. A health and safety audit carried out in June 2015 identified that the TV aerials remained a fire risk. The manager told us that a new aerial system had been fitted throughout the home for all TVs and that this had alleviated any risk of fire.

The manager completed a monthly audit on a variety of areas, including accidents, safeguarding, health and safety, infection control, pressure sores, staff training and staff absences. This information was also included in the monthly report that was submitted to the head office each month; this ensured that the registered provider was able to check that appropriate action had been taken by managers.