Raycare Limited

Summerhill

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Summerhill provides care, support and accommodation for up to 29 older people. There were 13 people living at the home at the time of our inspection.

People's experience of using this service and what we found
An effective system to assess, monitor and mitigate risks was not fully in place. Not all areas of the building were well maintained. Checks and remedial work had not been carried out as planned.

An electronic care management system had been introduced by the previous manager for the recording and monitoring of care plans and risk assessments. Staff who were able to use this system had left. Current staff were unable to fully use the system which meant that which meant that certain risks had not been assessed reviewed or documented.

Not all aspects of medicines management were carried out safely. Topical administration medicines records were in place, but these were not being used currently to evidence the administration of topical medicines.

Prior to our inspection, we received several anonymous whistleblowing concerns relating to people's care and support and the environment. We checked the concerns raised and reviewed people's electronic care records. Due to the poor standard of record keeping; electronic records did not fully document the care and support provided. We were therefore unable to fully check that people received care and support as planned.

We identified minor shortfalls relating to the use of PPE and infection control. We have made a recommendation about this.

A safe recruitment system was in place. People's needs were met by the number of staff on duty. Due to the current Covid-19 pandemic, occupancy levels had reduced.

There had been three managers at the home within the last 12 months. Several staff explained that this had been unsettling. They spoke positively about the new manager. Some staff said however, that the culture at the home was not always positive and staff did not always work together effectively as a team. We have made a recommendation about this.

Checks to monitor the quality and safety of the service were not being carried out. Timely action had not always been taken to address the shortfalls relating to the premises. Records relating to people, staff and the management of the service were not well maintained.

We acknowledged that the home had been through a difficult period due to the Covid-19 pandemic. The new manager was aware of the issues we had identified. Action was being taken to address the shortfalls.

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

Rating at last inspection
The last rating for this service was Good (published 15 March 2019)

Why we inspected
We received concerns in relation to people's care and treatment infection control, the environment and equipment, the management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led.

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

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well led key sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Summerhill on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so

We identified two breaches of the regulations relating to safe care and treatment and good governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Summerhill

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by one inspector.

Service and service type
Summerhill is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a manager in place. They were not yet registered with the Care Quality Commission. The provider Raycare Limited was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection

We spoke with eight members of staff including the manager, deputy manager, care staff, cook and housekeeper. We also spoke with two people. We reviewed electronic records relating to people's care and support. We also looked at medicines' records and maintenance records.

After the inspection
We sought clarification from the manager to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely;
- An effective system to assess, monitor and mitigate risks was not fully in place.
- Not all areas of the building were well maintained. Checks and remedial work had not been carried out as planned.
- Certain risks had not been assessed, reviewed or documented. An electronic care management system had been introduced by the previous manager for the recording and monitoring of care plans and risk assessments. Staff who were able to use this system had left. Current staff were unable to fully use the system.
- Not all aspects of medicines management were carried out safely. Topical administration medicines records were in place, but these were not being used currently to evidence the administration of topical medicines. Shortfalls were also identified with the storage of medicines.

The failure to have an effective system in place to monitor, manage and mitigate risks was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was aware of the issues we had highlighted and an action plan was in place to address the issues identified. They took immediate action regarding the storage of medicines.

Learning lessons when things go wrong
- An effective system to analyse accidents and incidents and identify and take action when things went wrong was not fully in place.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was aware of this issue and had designed an auditing system where all aspects of people's care would be monitored which would help identify any trends or concerns such as falls, weight loss and wounds.

Systems and processes to safeguard people from the risk of abuse;
- Records relating to people's care were not well maintained. Prior to our inspection, we received several anonymous whistleblowing concerns relating to people's care and support. We checked the concerns raised and reviewed people's electronic care records. Due to the poor standard of record keeping, electronic

records did not fully document the care and support provided. We were therefore unable to fully check that people received appropriate care and support as planned.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was taking action to ensure that care records reflected the care which was provided.

Preventing and controlling infection
● We identified minor shortfalls relating to the use of PPE and infection control. The manager told us these would be addressed.

We recommend the provider revisits best practice guidance in relation to infection control and the use of PPE, and reiterates this to staff as well as reviewing their practices regularly.

Staffing and recruitment
● People's needs were met by the number of staff on duty.
● The staffing tool did not consider the needs of people living with dementia to ensure sufficient staff were deployed once occupancy levels increased. The manager told us this would be addressed.
● A safe recruitment system was in place.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Checks to monitor the quality and safety of the service were not being carried out. Timely action had not been taken to address the shortfalls relating to the premises.
- Records were not well maintained. Records relating to staff; maintenance and the management of the service had either gone missing or were located in various places around the home and not easily found. Electronic care records did not always reflect the care which was provided. Care records had not been reviewed or audited because staff had not received training on how to use the system.

The failure to have an effective system to assess and monitor the quality and safety of the service was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action was being taken to address the shortfalls. Training on how to use the electronic care management system had been carried out.

- There had been three managers at the home within the last 12 months. Several staff explained that this had been unsettling; however, they spoke positively about the new manager. One staff member said, "I hope and pray that she will stay."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Several staff said that the culture at the home was not always positive and staff did not always work together effectively as a team. This is the second consecutive inspection where staff had raised concerns about the culture at the home. Although there was no evidence that the culture amongst staff had affected people's wellbeing; people living with dementia are sensitive to the interactions between staff and the social environment in which they live.
- We had received several anonymous whistleblowing concerns prior to our inspection. The manager recognised the importance of whistleblowing procedures. They stated they encouraged staff to raise concerns with either themselves or the provider so timely action could be taken. They said their door was always open and they welcomed all staff feedback.

We recommend that the provider keeps the day-to-day culture under review to ensure action is taken if any

concerns are raised.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager and deputy manager were open and honest throughout the inspection. They were aware of the action which needed to be carried out and the challenges this involved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Processes were in place to involve people and staff in the running of the home.

Working in partnership with others

● The home were working with the local authority with regards to the improvements required at the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment An effective system was not fully in place to assess, monitor and mitigate risks relating to people's care and support, the environment and medicines management. Regulation 12 (1)(2)(a)(b)(c)(d)(g).

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not fully in place to monitor the quality and safety of the service. Records relating to people's care and support, the management of staff and the management of the home were not always accurate or up to date. Regulation 17 (1)(2)(a)(b)(c)(d)(I)(ii).

The enforcement action we took:

We issued a warning notice.