# Summerfield Medical Limited

# Summerfield Nursing Unit

**Inspection report**

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## Ratings

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

## Overall summary

This inspection took place on 21 and 24 November 2014 and was unannounced.

Summerfield Nursing Unit provides accommodation and nursing care for up to 66 people who have nursing needs. At the time of our inspection there were 53 people living in the home. The home is a four floor, purpose built building. Each floor had a lounge, dining room and small kitchen. A cinema, library, hairdresser's salon and gardens were available to people who live in the home.

A registered manager was in place as required by their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what actions we told the provider to take at the back of the full version of this report. People and the relatives were mainly positive about the care they received however we found people's safety and well-being was compromised in a number of areas.

# Summary of findings

Some people's individual risks were not being assessed, monitored or recorded. Their care records were not kept up to date and did not always provide staff with relevant and detailed information about the care and support needs of individuals. People's preferences, goals and personal histories were not recorded. Some people had moved into the home without a comprehensive assessment of what help they needed with their care to ensure that the home and staff could meet these needs.

Staff were not familiar with the Mental Capacity Act 2005 and their legal responsibility on how to support people who lacked capacity. People's mental capacity to make day to day or significant decisions had not been thoroughly assessed or recorded, although some staff knew people well enough to understand their preferences. Records of best interest decisions made on behalf of people were not in place. Staff were knowledgeable about protecting people from harm and abuse but they were unable to tell us where they would report their concerns outside the home.

The provider's management of medicines policy did not reflect the practices in the home. Although most people's medicines were managed effectively this was not consistent for all people. Some people were not given their medicines at the correct time.

Staff training was not effectively managed and monitored to ensure people were being cared for by staff with the appropriate skills. There were gaps in some of the staff recruitment processes which are intended to ensure the suitably of staff is checked before they care for people.

People gave mixed comments about the meals. Some people enjoyed their meals, others felt there could be more choices especially at breakfast. People who had specific dietary needs were catered for. However the fluid and food intake for some people who were at risk of not eating and drinking was not always monitored and recorded.

People and their relatives spoke positively about the staff and the registered manager. We saw they were kind and considerate when they helped people with their personal care but there was very little meaningful social interaction between people and staff.

The provider had not actively sought feedback from people about their experiences and views of living in the home. However, the provider had acted on some people's concerns such as helping them keep in contact with their families. The provider dealt with complaints and concerns on a day to day basis.

Quality monitoring of the building and facilities had been carried out but there was no system in place to audit and monitor the quality of the service provided to the people who lived in the home. Information which the provider sent to us was not detailed and not sent to us in a timely manner.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Inadequate** 

The service was not safe. Some people's individual risks were not being assessed, managed or recorded, therefore plans were not put into place to guide staff on how to manage and reduce these risks. Some people's medicines were not always being managed, administered and recorded correctly. The medicines policy did not reflect the practices of the administration of people's medicines in the home.

People were not always cared for by suitably recruited staff. The systems to check the employment history of new staff were not thorough. Staffing levels in the home were not always sufficient to meet people's needs.

**Is the service effective?**

**Inadequate** 

The service was not effective. People were being cared for by staff who had not been adequately trained to meet their needs. New staff were not fully trained before they became a member of the team and cared for people.

Assessments of people's mental capacity had not been carried out. Whilst staff supported people to make decisions about their care, there were no records to support any best interest decisions made on their behalf.

People's dietary needs and choices were catered for. The food and fluid intakes for some people who were at risk of not eating and drinking were not always recorded.

**Is the service caring?**

**Requires Improvement** 

The service was not consistently caring. Whilst staff interactions were mainly caring when helping people with personal care, there was little social interaction between people and staff.

People's care records were not securely stored. People were not cared for in a personalised way as their care records did not provide staff with information about their individual backgrounds and preferences.

People and their relatives were positive about the staff who cared for them. Staff respected people's dignity and privacy when supporting them with their personal care.

**Is the service responsive?**

**Inadequate** 

The service was not responsive to people's needs. People's care records did not reflect their individual needs and support. There were limited opportunities for people to carry out activities or socialise with other people.

The registered manager and provider dealt with any issues from people and their families on a day to day basis and had acted on some people's concerns.

# Summary of findings

**Is the service well-led?**

The service was not well led. Systems were not in place to monitor the quality of the service and identify any shortfalls. People's views and experiences of living in the home were not actively sought. Information and significant events were not shared with CQC in a timely and detailed manner.

People and relatives spoke positively about the registered manager. The provider had made some changes as a result of people's feedback.

**Requires Improvement**

# 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.

This inspection took place on 21 and 24 November and was unannounced. The inspection was led by one inspector who was accompanied by a second 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. Their area of expertise was in caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the provider and previous inspection reports.

We spent time walking around the home and observing how staff interacted with people. We spoke with 15 people, six relatives, eight members of staff, the registered manager, two senior managers and the director of the service. We looked at the care records of eight people. We also spoke with two health and social care professionals. We looked at staff files including recruitment procedures and the training and development of staff. We checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Inadequate

# Is the service safe?

## Our findings

People were not always protected from harm as not all people had individual risk assessments. People's care records did not always reflect their needs and the support which they required. Staff told us they used staff meetings between shifts to share information about people rather than referring to people's care records because they were not always kept up to date. In one situation, this had resulted in staff missing some important information about the support one person required. This person's care records stated that they should not be moved in a certain way due to their medical condition. Their daily records told us staff were not supporting this person in accordance with their care plan. This person was therefore at risk of being harmed by being moved in an inappropriate way.

People's risks were not being recorded and monitored. For example, there were no risk assessments for people who were cared for in bed with bed rails. There was limited information to guide staff on how people should be supported with their mobility or using a hoist. The management and monitoring of some people's pressure areas was not being recorded. The needs of people who had moved into the home from hospital for a short assessment period had not been reviewed or reassessed by the home. This meant staff were not provided with up to date or relevant information about how people should be supported to reduce their risk of harm. This information is especially significant for people who were supported by agency staff and may not be familiar with their care and support needs. This is a breach of Regulation 20, Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

People's medicines were not always managed safely. On the day of our inspection, people were not given their medicines at the correct time. We were told this was because the nurse responsible for the administration of people's medicines had been busy. Most medicines records were correct. However we found poor records for a liquid medicine that had been prescribed for one person. This medicine did not have the person's name on it and the contents of the bottle did not reflect the amount which had been recorded as being administered to the person.

Another person who was in a lot of pain had not been given his daily pain medication at the required time. We saw that this person did go on to have their correct pain relief medication.

A general medicines policy was in place but it did not reflect the practices of medicine management in the home. One qualified nurse was unaware of the providers' policy and protocols for administering homely medicines. Homely medicines are non-prescription medicine which the staff may administer to a person if required. We found one person had been given a homely remedy medicine which was labelled for another person. The medicines policy stated people would be encouraged to administer their own medicines. However we were told by qualified nurse, "It is easier if we take control of their medicines." We found there was no pain assessment or guidance for staff to give one person pain relief when they required it.

People's medicines were ordered, checked in and signed for by a nurse and then stored in individual wall mounted lockable cabinets in their bedrooms. Homely remedies, medicines which were required to be refrigerated and controlled drugs were stored securely and separately in the treatments room. Records of medicines which were for disposal had been completed. There was no regular documented monitoring or auditing checks of people's medicines to ensure that people were safe from being given the wrong medicines. This is a breach of Regulation 13, Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

Staff had a good understanding of safeguarding people and how to report any concerns within the home however people were not always cared for by staff who knew where to report allegations of abuse outside the home. New staff had learnt about safeguarding people on their induction course but they were not informed about how to contact local agencies and authorities to report their concerns. The provider's safeguarding policy also did not provide staff with local contacts and information. This meant that staff did not always know where to report any concerns about people if these concerns were not managed appropriately within the home.

Whilst some good recruitment practices were in place to ensure that people were being supported by suitable staff, these practices were not consistently thorough. The provider had carried out police checks; however improvement in checking staff's employment history was

Inadequate

# Is the service safe?

required. For example one staff member, who had previously worked with vulnerable people, had not had their work history fully explored. The provider told us they always ensured that they were satisfied with the conduct and behaviours of new staff before they became part of the team. They said “We always make sure new staff work under close supervision and their approach to working with people is checked to ensure they are the right person for the job.”

Prior to our inspection we received concerns from relatives about the staffing levels within the home. The registered manager told us they aimed to have a qualified nurse and four care staff on each floor during the day which reduced in the evenings and overnight. The home relied on agency staff to maintain these staffing levels. On the days of inspection we found that suitable staffing levels to meet the needs of the people were in place. The registered manager monitored the staffing levels however staff told us that these levels were not always maintained. Staff confirmed they were sometimes short of staff. Records of staff rotas showed there had been an occasional shift when there was not enough staff to support the people in the home. The registered manager told us that this had been due to agency staff letting them down. The registered manager told us they were actively recruiting new staff to reduce the need to rely on agency staff.

Inadequate

# Is the service effective?

## Our findings

People were supported by staff whose care skills and knowledge were not regularly reviewed and updated. There was an inconsistent approach in supporting staff to develop in their role. New staff had been trained in moving and handling and safeguarding people before they started to support and care for people. They had been given information on infection control and a care skills handbook to read and were given the provider's policies to read. New staff spent time with an experienced member of staff before they became part of the team. We were told that other relevant training in supporting people such as health and safety would be provided later; however there was no evidence that these plans were in place. Not all staff had received training in Mental Capacity Act 2005 (MCA) so could not tell us their legal responsibilities in supporting people's rights and freedom.

Some staff had received individual support meetings but we found the records of these meetings did not reflect their discussions or areas of performance or training requirements. Staff training and knowledge was not being regularly monitored during these meetings to ensure their skills were in line with current care practices. A new electronic system was in place to record and monitor staff training but this was not being effectively used. A member of staff had recently been trained to train other staff however there were no plans in place to demonstrate how they would keep their training knowledge in line with current practices, other than by personal research. This is a breach of Regulation 23, Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw staff assisting people as much as possible to help them make an informed choice such as showing them options of clothing to wear. Staff made a decision for some people based on their known preferences and likes. Staff understood the importance of involving people in their care and providing them with choice and options. Some people in the home did not have the mental capacity to give consent to their care. People's mental capacity assessments had not been fully completed and did not identify specific areas where people needed support to make decisions. Some people's records did not describe the reasons behind the best interest decisions made on behalf of people. This is a breach of Regulation 18, Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us no one living in the home was being deprived of their liberty. The registered manager understood the law which protects people's rights and freedom. The registered manager had contacted the Deprivation of Liberty (DoLS) team when they thought somebody's freedom was potentially restricted to seek advice and guidance. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been considered and authorised by the local authority as being required to protect the person from harm.

We were told about one person who had recently moved into the home who became occasionally anxious. Staff supported this person and helped to reassure them.

People's health and clinical needs were not always assessed to identify any risks or confirm the regime of nursing care required. The registered manager told us that where possible, people were pre-assessed by a qualified nurse before the decision was made that the home was suitable for the individual person. We were told some people moved into the home without a comprehensive preadmission assessment carried out by the home's qualified nurse. This meant that there was a risk that people's specific health risks were not fully identified and understood before they received care in the home.

When people's care needs changed they were referred to the appropriate health care service for additional support and treatment. One palliative care nurse said "This home is on the ball! If the staff are not sure about someone's health they always ask and implement our recommendations." The registered manager told us that they were trying to develop a professional relationship with the local GP surgeries to help to bring a continuity of care for people. Some people had chosen to stay with their original GP. Relatives told us they were always kept informed in any changes in people's health.

Some people's nutritional and fluid charts did not always reflect their intake and were not effectively recorded and monitored which put people at risk of malnutrition and dehydration. We received mixed comments about the meals provided. A range of breakfast food was available for

Inadequate

# Is the service effective?

people but one person told us they were not aware that they could have cooked eggs in the mornings. Another person said they would like bacon but this was not offered except for on Sundays when a full English breakfast was offered to everyone.

People were offered a choice of two hot meals. Ready-made meals were bought in frozen and heated up. We were told that this arrangement was temporary and was being reviewed by the provider. The meal containers provided staff with the nutritional values for each meal. Portion sizes were flexible and dependent on people's appetites.

People with specific dietary needs were catered for. One person who was a vegetarian said, "They always do me nice food. I'm spoilt." People with swallowing difficulties were offered a choice of soft or pureed meals. Optional food such as jacket potatoes or soup was available if people did not like the meal choices. Staff knew people well and were able to help them make a choice about their preferred meal. One member of staff told a person, "I am not sure that you will like the quiche but try it anyway. If you don't like it I will get you something else." People were offered a range of food and refreshments throughout the day. Some people chose to eat in the dining room or their bedrooms.

Requires Improvement

# Is the service caring?

## Our findings

People who were able to talk to us said staff were respectful and caring. Our observations of staff interacting with people confirmed this. One person said, “They are lovely here. Very attentive.” and “Staff are very caring, I couldn’t ask for better.” Another person said, “Staff are wonderful. Nothing I can fault.”

One friend who was visiting a person in the home asked specifically to speak to us and said, “The staff are really really kind, they are exceptionally kind to him.” They went on to tell us the staff make visitors feel very welcome and empathised with their concerns and worries. Other relatives told us staff were very respectful and polite. We were told that relative’s felt welcomed by staff and were always happy to speak to them. One relative talked about their experience of the home when they visited their wife. They said, “I don’t think they could look after us any better. We’re really looked after, nothing’s too much trouble. I don’t think they could get a better place for us.”

Some staff did not fully understand the individual needs and requirements of people. For example, one person who sat resting in the cinema area had to ask for their hearing aid. One staff member willingly collected the hearing aid from their room but was not familiar with the type of hearing aid and had to ask another member of staff for assistance. Another person told us that they always had to ask for their glasses as they could not see the remote control for the television. They said “You would think they could give me my glasses before they go to see to the next person.”

We observed that although staff were caring in their approach, there was very little interaction with people who spent time in their bedrooms other than activities around personal care and support. People who were quiet were given minimal attention. Personalised care by new staff and agency staff was limited as people’s care records did not provide staff with their personal and social histories.

People’s privacy was not always considered. Information about people and their care records were kept in the nurse’s office which remained unlocked during our inspection. This meant people had access to personal information about other people. However the care provided by staff was respectful and people’s privacy was respected when personal care was delivered. People and their relatives confirmed this. Most relatives visited and spoke to people privately in their rooms. A library and bar area was also available for people and their families to use. The registered managers told us that the bar area was to be turned into a coffee and tea room to encourage people to socialise.

The home encouraged people to stay in contact with their family members by telephone or video calling families. Some people had another family member also living in the home. Staff helped these people to remain in contact with each other despite having complex nursing needs.

Inadequate

# Is the service responsive?

## Our findings

Some people's care records were inconsistent and did not give staff the guidance they required to support and care for people. There was little information about people's preferences or personal history. Some people's care assessments and plans had not been carried out since they moved into the home.

Some people's records did not give staff clear guidance on how to care and communicate with people. For example, one person was unable to verbally communicate their needs. Staff were able to tell us how this person expressed their pain but this was not recorded in their care records. There was no assessment of pain for this person or guidance for staff although the daily record notes referred to a doctor being contacted for pain relief for this person. Detailed guidance or protocols on how to carry out certain personal procedures were not in place. One person said, "Some staff are better at it than others."

People's care records did not reflect their social and emotional wellbeing or their level of independence. Staff were able to tell us how they cared for people in a way that supported people's choices and ensured that their needs were at the centre of their care. However the care records did not always reflect this. Some people's care records did not reflect their preferences or social and past histories. This meant new staff or agency staff were not always given personal and relevant information about people which may have been important to their delivery of care.

Some people spent a lot of their day in bed. Their care records did not state whether this was people's preference or a medical need. Assessments had not always been carried out to identify the risks associated with being in bed all day such as the development of pressure areas and social isolation. The approach to treating and recording people's pressure sores areas was inconsistent. For example, one person had not always been repositioned in their bed at the recommended times and their pressure mattress was not set at the correct level for their weight. These practices person's skin viability at risk.

This is a breach of Regulation 9, Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Individual and group activities for people were limited. Most people stayed in their rooms and slept or watched television. One person said, "I am bored, I hardly leave this room." We were told that volunteers regularly visited two people to carry out individual activities such as hand massage.

People could have their haircut and styled in the home's hairdressing salon or in their bedrooms. A film was shown every afternoon in the cinema. Poster's around the home advertised the film which would be shown each day, however not everyone was aware of this facility. The home also had a library which people and their relatives could use.

The provider's complaints policy was on display on each floor which explained their complaints procedures and contact details. We were told that any concerns from people or their relatives were dealt with promptly. We saw that one complaint had been managed in line with their complaints policy.

Requires Improvement

# Is the service well-led?

## Our findings

Whilst we observed that staff were kind and compassionate, they were unable to tell us about the values and vision of the home. There was no evidence of a drive for improvement or aspirations for high quality care from the provider, senior staff or registered manager. People told us they were happy at the home but their experiences and views of their stay were not actively sought by the provider or registered manager.

We were told the provider and registered manager had an open door policy and acted on people's immediate concerns. However, some people with more complex communication needs may not have the opportunity to express their views about the service as alternative methods of communication had not been considered. The provider had not actively sought feedback from people, relatives or their staff about the service provided by the home. This meant they were not fully aware of people's experiences of living in the home and had not identified good practices or short falls in the service provided. Since our inspection, we were made aware of a complaint by a relative that the provider was dealing with but this had not been shared with us or held in the complaints file. Therefore the provider was not always transparent in managing complaints.

The provider was able to give us examples where people had raised concerns and they had been acted on. For example, it was important for one person to communicate with family by telephone daily. This person was unable to get a mobile telephone signal due to the location of the home. The provider installed a landline in everyone's bedroom.

The provider and registered manager were open and supportive. Staff told us they could raise any concerns with the registered manager and they felt supported. One staff member said, "The managers here are open to comments and ideas and will act on them if they think they are reasonable." However staff told us that they did not always know what was going on the home. Staff meetings were not carried out on a regular basis and notice boards were not kept up to date.

Although the registered manager informed us of any significant incidents or events that affected the service or people; this was not always done in a timely way. We found that information provided by the registered manager was not always adequately detailed. The provider information return (PIR) which we asked the provider to complete before this inspection provided us with very little key information about the service such as what the service does well and improvements they plan to make.

The provider did not carry out any quality audits of the service and care provided to people who lived in the home. The registered manager and qualified nurses carried out reviews of people's care records but the provider did not monitor the quality of the service provided and identify any shortfalls. Accident and incidents had been recorded but although individual incidents had been reviewed there was no overview of any trends or patterns of incidents that had occurred in the home.

This is a breach of Regulation 10, Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Audits of the maintenance of the building and equipment were being regularly monitored and checked which included health and safety checks. Hoists and electrical equipment which people relied on such as electrical beds were regularly serviced and checked. Any faults were acted on immediately. The fire safety systems had been regularly checked to ensure people remained safe in the event of a fire. Cleaning schedules were in place to ensure the home was clean and people were protected from infections.

People and their relatives were positive about the registered manager. We received comments such as "The matron (registered manager) is the best ever, she looks after me and if I want anything she tries her best to get if for me." and "Give credit to the manager – no matter what time of day it is you can always speak to her."

The home had limited links with the community although a religious service was carried out monthly. We were told that as the provider was new, they had not yet built up community and local links.

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 | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br><br>**The registered person did not have effective systems in place to monitor the quality of the service delivery.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>**The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br><br>**The registered person did protect people against the risk of unsafe and inappropriate care and treatment arising from a lack of proper information about them.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br><br>**The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying out regulated activities receive appropriate training, professional development and supervision.** |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines. |

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>**The registered person did not take on proper steps to ensure each service user received care that was appropriate and safe.** |

**The enforcement action we took:**

We issued a Warning Notice under Section 29 of the Health and Social Care Act 2008 for failing to comply with regulation 9. The provider, Summerfield Medical Limited and registered manager is required to become compliant with this at of Summerfield Nursing Unit by 31st January 2015.