Bondcare (Halifax) Limited

Summerfield House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Summerfield House Nursing Home is a residential care home providing nursing and personal care for up to 107 people, some of whom may be living with dementia. The home is purpose built providing accommodation on three floors – Oak, Cedar and Maple. Each floor has separate adapted facilities. Cedar specialises in providing care to people living with dementia and Maple provides nursing care. On the first day we inspected there were 89 people using the service and 91 people when we visited on 2 March 2023.

People's experience of using this service and what we found
People were at risk of harm as the provider had not always identified, assessed or mitigated risks. Medicines were not always managed safely.

There were not always enough staff to meet people's needs and keep them safe. Staff training was kept up to date, though some staff required further specialist training in dementia care and Parkinson's disease. This was being organised by the manager.

Quality audits were not always effective in identifying or securing improvements. The provider had identified some issues and started to address these through their service improvement plan. People's care records were variable. Some had detailed and personalised information, whereas others were not always accurate and up to date.

People enjoyed the food and nutritional needs were met, however mealtime experiences varied and some practices needed to improve.

Recruitment processes were robust. People said they felt safe in the home and safeguarding incidents were recognised and reported. The environment was clean and well maintained. Infection control was well managed.

People and relatives were generally positive about the service. Staff were described as kind and caring. People were supported to keep in touch with family and friends. People had access to healthcare services. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The manager took action during the inspection to address some of the issues we raised.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 15 July 2022) and there were breaches

of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 17 and 23 May 2022. Breaches of legal requirements were found. We served a warning notice regarding medicines in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

The inspection was also prompted in part due to concerns received about medicines and safeguarding. As a result, we undertook a focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective 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 COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Summerfield House Nursing Home

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 Health and Social Care Act 2008.

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
Three inspectors, a medicines inspector and 2 Experts by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Summerfield House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Summerfield house Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The regional manager was managing the service.

Notice of inspection
This inspection was unannounced. Inspection activity started on 16 February 2023 and ended on 9 March 2023. We visited the location's service on 16 and 23 February 2023 and 2 March 2023. On 22 February and 7 and 9 March we reviewed documentation remotely and spoke with staff on the phone.

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 and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time with people in the communal areas observing the care and support provided by staff. We spoke with 15 people who used the service and 13 relatives about their experience of the care provided. We spoke with 16 staff including the manager, senior managers, nurses, senior care workers and care workers. We also spoke with 3 visiting healthcare professionals.

We reviewed a range of records. This included 15 people's care records and 15 people's medicine records. We looked at 2 staff recruitment files. A variety of records relating to the management of the service were reviewed

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

Using medicines safely

At our last inspection the provider had failed to ensure safe medicine management systems were in place. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Medicines were not always managed safely.
- Medicines were stored safely and at the right temperature. However, medicines that are controlled drugs were not disposed of in the right way.
- Staff administered medicines in a safe and kind way. However, when we looked at people's medication administration records (MARs) we found a medicine error had been made. The manager took appropriate action when we brought this to their attention.
- People were being given their medicine to treat Parkinson's disease at the right times. However, one person was not given their antibiotic medicine in the way prescribed on three consecutive days.
- Pain relief medication for two people was out of stock for several days.

Systems were either not in place or robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They said action had and was being taken to address these issues.

- Medication audits performed by managers were effective in improving medicines management as shortfalls were noted and an action plan put in place. When people did not receive their medication as prescribed this was reported as a safeguarding incident.
- One relative told us how proactive staff had been in contacting the GP to review a medicine that was making their family member very sleepy.

Assessing risk, safety monitoring and management

- Risks to people were not assessed and managed safely placing people at risk of harm or injury.
- Risk assessments were not always in place. One person had experienced a fall in December 2022. There was no falls risk assessment and the falls log stated there had been no falls. Another person who had sustained a fracture from a fall, prior to their admission to the home, had no risk assessments for falls or

mobility 16 days after they had been admitted.
● Risk assessments were not always updated. One person had 7 falls between December 2022 and February 2023. The falls risk assessment showed only one fall and had not been updated.
● Risks were not always identified and acted upon. One person was unsupported by staff with food and drink until alerted by the inspector. The person had diabetes and required food and drink within a certain time period to avoid low blood sugar following a fast-acting insulin injection. Staff gave another person food which was not compatible with their dietary requirements.
● Wound treatment records for two people were not accurate or up to date.

The lack of robust risk management processes meant people were not always protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection and sent information to show they were taking action.

● The environment was safe and well maintained. Safety checks of the premises and equipment were up to date.
● We observed good moving and handling practices when staff were assisting people to transfer. Handling belts and hoists were used appropriately; wheelchair brakes were applied before people were supported to move.

Staffing and recruitment
● There were not always enough staff deployed to meet people's needs and keep them safe.
● People, relatives and staff reported a high turnover of staff. Six out of 8 care staff we spoke with said there were not enough staff. They acknowledged managers tried to cover any shortages with agency or asked permanent staff to pick up extra shifts.
● Staff described not having enough time to support people properly. One staff member said, "I feel overwhelmed with what needs to be done. Often we're only able to give the bare minimum of care as we're rushing to get to next person. It's not fair on them. If someone calls for help you often have to tell them you'll come back as you're providing support to someone else."
● Some people reported having to wait a long time for staff to come. Comments included; "Most of the time there's not enough staff. It makes me depressed because I don't think I'm getting anywhere. I want to be able to walk" and "I press [the call bell] bleep, bleep, bleep and they don't come. I feel frustrated they say they 'have so many people to look after', they should get more staff."
● Oversight and direction of staff needed to improve. Staff reported some staff members did not 'pull their weight' placing more pressure on other staff. We saw a staff member sat in a room where there were no people for over half an hour until care staff asked them to go into the lounge with people. Another staff member who was providing 1:1 support for the first time had not been given any information about the person they were supporting.

There were not enough staff deployed at all times to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Robust recruitment processes were in place with all checks carried out before staff were employed.
● The manager told us there was an ongoing recruitment drive to secure more staff, including the recruitment of overseas nurses. The manager tried to ensure regular agency staff were used to provided consistency and continuity.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse or harm. One person said, "I'm eminently safe; the staff fill me with confidence, they are friendly and knowledgeable."

● Staff had completed safeguarding training and understood their responsibility to report concerns.

● Safeguarding incidents were reported, recorded and showed the action taken to ensure people's safety. Referrals had been made to the local authority safeguarding team and notified to CQC.

Preventing and controlling infection

● We were assured the provider was preventing visitors from catching and spreading infections.

● We were assured the provider was supporting people living at the service to minimise the spread of infection.

● We were assured the provider was admitting people safely to the service.

● We were assured the provider was using PPE effectively and safely.

● We were assured the provider was responding effectively to risks and signs of infection.

● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes

● Relatives and friends were able to visit people in accordance with current government guidance. Relatives we spoke with said they were happy with the visiting arrangements and could visit when they wanted.

Learning lessons when things go wrong

● Systems were in place to manage and monitor falls and safeguarding.

● Some care records showed actions taken to prevent future risks to individuals and lessons learnt. For example, people that had fallen had sensor equipment put in place and were referred to the falls team.

● The manager said lessons learnt were discussed at clinical and care staff meetings.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People's nutritional needs and preferences were met.
- Menus offered a choice at each mealtime and drinks and snacks were available throughout the day. However, people had to choose their dinner and tea the day before which was confusing for people living with dementia. We were close to 1 person when they were asked by staff what meal they would like the following day. The person asked us, "Does she mean tomorrow? I don't know what I'll want."
- At breakfast people were asked what they would like to eat and drink. We saw some people may have benefitted from staff showing them the food to help them make a choice. At dinner time there was minimal choice offered as meals were plated by staff as ordered the day before.
- Staff were patient and kind when supporting people who needed assistance with their meals. However, we observed two instances where staff did not communicate with people or support them in a dignified way. The manager said they would take action to address these issues.
- People told us they liked the food. Comments included; "I love the food especially the porridge it's so creamy"; "I scoff the food, it's really good" and "We get lots of treats. I like the chocolate biscuits."
- People who were nutritionally at risk had their food intake and weight monitored. Specialist diets and fortified meals and snacks were provided. A relative said their family member had lost a lot of weight in hospital before coming to the home but were pleased they had now put the weight back on.

Staff support: induction, training, skills and experience

- Staff received the induction, training and support they required to fulfil their roles.
- Staff said the training was good and kept up to date. The matrix identified when training was due, updates were booked and monitored by management.
- Our observations showed some staff needed further training in dementia care and Parkinson's disease. We saw a person living with dementia trying to wash their mug in the sink in the dining room. Staff said they would do it and told the person to sit down. This was a missed opportunity to engage the person in a meaningful activity.
- One relative and another person told us some staff lacked understanding about the impact of Parkinson's disease on a person's mobility. The person said a staff member commented, "You could walk yesterday why can't you do it today?"
- The manager told us they were arranging further training sessions. A Parkinson's disease training session took place on 6 March 2023. A staff member who attended told us they had learnt a lot of things they had not previously known.

● Some staff said they had received supervision. The matrix showed some supervisions had taken place in January 2023 and others were planned in for the rest of the year.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The service was working within the principles of the MCA.
● A DoLS tracker was in place which showed when applications had been made and granted.
● One DoLS authorisation we checked had a condition and this had been met.
● Staff explained and asked people for consent before providing care and support. For example, before assisting people to eat and using equipment to help people transfer.
● Mental capacity assessments and best interest decisions (BID) were recorded for some, but not all decisions where people lacked capacity. For example, 1 person had no assessment or BID for sensor equipment that was in place. This was addressed by the manager.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● People's needs were assessed before they moved into the home to ensure their needs could be met.
● The service was purpose-built and provided spacious accommodation for people. Bedrooms were personalised, decorated and furnished to a high standard. There were a variety of communal areas throughout the home where people could spend time. Corridors and doorways were wide and provided people with space to mobilise safely.
● Signs, colours and pictures were used to aid people with a visual impairment or those living with dementia.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access healthcare services. One relative said the staff were very responsive when their family member was ill. They said staff accompanied them to the hospital and supported them to ask the right questions to ensure the person received the right care. They said staff ensured everything was ready for the person when they returned to the home.
● Staff monitored people's health care needs and made referrals to appropriate healthcare professionals. This was confirmed in the care records we reviewed.

Requires Improvement

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure safe systems were in place to monitor the safety and quality of medicine management. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● We found shortfalls at this inspection with regulatory breaches relating to medicines, risk management and staffing. The provider had identified some of these issues and started to address these through their service improvement plan.
● Quality audits were not always effective in identifying or securing improvements. For example, care plan audits had identified actions to be completed by the end of February 2023 and not all actions had been done. Monthly falls analysis from November 2022 to January 2023 identified the majority of falls were unwitnessed occurring in the afternoon and evening. There was no information to show whether this trend had been investigated further to look at ways of reducing unwitnessed falls. There was no analysis of other incidents and accidents.
● People's care records were variable. Some had detailed and personalised information, whereas others were not always accurate and up to date. For example, 1 person's care records gave inaccurate information about medical equipment they used. Another person's care plan had not been updated to reflect the state of their skin and the treatment they required.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded promptly to our feedback during and after the inspection. They confirmed action they had taken to make improvements.

● The registered manager left in January 2023 and the regional manager has been managing the service. Recruitment for a new manager was ongoing.

● People, relatives and staff spoke positively about the improvements made since the regional manager had been managing the home. They said the manager was approachable, listened and acted on issues 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 understood their responsibility to be open and transparent. They informed people, relatives and relevant professionals when things went wrong.

● Two relatives told us of concerns they had about the care being provided to their family members. These had been reported to the manager who was taking action to address the issues. A different relative told us concerns they had raised had been addressed. They said, "It is a home we would recommend. When you raise concerns, you feel you are being listened to."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The majority of people and relatives we spoke with were happy with the care provided. Comments included; "The care [family member] receives at the home has prolonged their life. They came in for end of life care 12 months ago"; "I would recommend this home. This is my first experience of care, but it has been positive" and "I am very pleased with it here. It's first class, it's very good."

● People and relatives praised the staff. Comments included; "Staff are very calm and patient. They can do for my [family member] what we have not been able to do for years"; "The overriding thing is that they treat people how you would like to be treated" and "Staff are lovely and very good to me."

● Minutes from residents, relatives and staff meetings showed their involvement in making decisions about the running of the home.

● Recent surveys had been completed by people, relatives and staff. Analysis showed the actions being taken to address the issues raised.

● Care records showed the service worked in partnership with health and social care professionals. One health care professional told us the management team were very willing to work with them, the GP and pharmacy to make improvements to the medicines processes.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not assessed, mitigated or monitored. Medicines were not managed safely. Regulation 12 (2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and mitigate risks to people or to improve the quality of the service. Accurate, complete and contemporaneous records were not in place in relation to each service user's care and treatment. Regulation 17 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experience staff were not effectively deployed to meet people's needs. Regulation 18 (1)(2)(a)