Bondcare (Halifax) Limited

Summerfield House Nursing Home

Inspection report

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Date of inspection visit:
20 April 2021
28 April 2021

Date of publication:
22 September 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Summerfield House Nursing Home is a care home providing nursing and residential care to people aged 65 and over, some of whom live with dementia. At the time of the inspection 91 people were using the service. They can support up to 107 people. The care home is purpose-built and accommodates people across three separate units, each of which has adapted facilities.

People's experience of using this service and what we found
Medicines were not always managed safely. Staff did not have access to sufficient information about how to administer some medicines in a person-centred way. People felt safe living at Summerfield House Nursing Home and that their personal belongings were safe. Accidents and incidents were recorded and monitored by the management team, and risks to people were assessed and managed. Staff understood whistle-blowing procedures and told us they would always report any concerns to a member of the management team. They were confident any issues would be dealt with appropriately. Staffing arrangements kept people safe. The service followed safe infection, prevention and control procedures.

Quality monitoring systems were in place and usually identified good practice, concerns and actions to drive improvement. However, audits had not highlighted shortfalls in the medicine management system. Notifications about significant events were not always reported to CQC without delay.

People's experience at Summerfield House Nursing Home was positive. They found staff and management were kind and caring. One person said, "They make us so comfortable and create a lovely atmosphere." The registered manager was engaging and knowledgeable about the service. They were responsive to the inspection findings and shared evidence they were taking action to address shortfalls.

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 25 March 2020) and there were three 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 some improvements had been made and the provider was no longer in breach of two of the regulations. However, they were still in breach of one regulation.

Why we inspected
The inspection was prompted in part due to concerns about medicines, staffing and management. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key

questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating 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.

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.

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

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 monitor the service.

We have identified a breach in relation to managing medicines safely.

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 for 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 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?

Good

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 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
Two inspectors, a medicines inspector and an Expert by Experience carried out the 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 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We announced the inspection shortly before we entered the service so we could check the arrangements in place for preventing and containing transmission of Covid-19. Inspection activity started on 20 April 2021

and ended on 30 April 2021. We visited the service on 20 April 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioners and safeguarding team. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with seven people who used the service and five relatives about their experience of the care provided. We spoke with 12 members of staff including the registered manager, night manager, nurses, laundry assistant, senior care workers and care workers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and a variety of records relating to the management of the service.

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 as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At the last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe care and treatment) 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. Systems to ensure people received time specific medicine at the right time were not robust. After the site visit the registered manager confirmed reminders had been reviewed and updated on the electronic medication system which would ensure medication administration would meet people's specific needs.
● Staff did not have access to sufficient information about how to apply some topical creams or administer 'as required' medicines in a person-centred way. The registered manager explained protocols had been archived when the service transferred over to the electronic medication system and new protocols were introduced following the site visit.
● Best interest decisions involving other professionals were in place when people received their medicines covertly (hidden in food or drink). However, information about how to disguise the medicine without reducing its effectiveness was not kept with the electronic administration records.

We found no evidence that people had been harmed. However, medicines management was not safe which placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored correctly and disposed of safely
● The provider had up to date guidance for managing medicines.

Staffing and recruitment

At the last inspection the provider had failed to ensure staff were deployed effectively. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Enough staff were deployed to keep people safe. The provider used a dependency tool to help calculate staffing levels.
● People told us staffing arrangements generally worked well, although some concerns were shared that short notice staff shortages were not always covered. One member of staff said, "Management try to get cover if we are short, but the pandemic has made it harder getting cover." The registered manager was confident additional cover was arranged when required and explained they had some flexibility around staffing numbers due to the reduced number of people using the service.
● Staff had the right mix of skills to meet people's needs. People told us staff were trained and competent. One person said, "They are very skilled." A relative said, "They certainly understand the needs of someone with Alzheimer's."
● Recruitment checks were carried out before staff commenced employment. Staff files were well organised and had evidence that staff had received job descriptions, contracts of employment and agreed to complete mandatory online training within the probationary period. Staff completed a combination of application form and curriculum vitae but these did not always show their full employment history. The registered manager agreed to ensure this was carefully monitored in future.

Systems and processes to safeguard people from the risk of abuse
● People felt safe living at Summerfield House Nursing Home. They told us their personal belongings were safe. One person said, "Very safe, if I wasn't, I would speak to them about it."
● Safeguarding concerns were managed promptly and effectively. Events were reported to the local safeguarding authority and appropriate records were maintained. The registered manager confirmed there were no open safeguarding cases.
● Staff completed safeguarding training and knew how to identify and respond to concerns. Staff understood whistle-blowing procedures and told us they would always report any concerns to a member of the management team and were confident they would deal with issues appropriately. One member of staff said, [Name of registered manager] will always listen and responds to any concerns ."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people were assessed and managed. Care files had assessments which were reviewed and showed action was taken to reduce the risk of harm. Examples included people having equipment to keep them safe and support from other professionals such as falls prevention specialists.
● Accidents and incidents were recorded and monitored by the management team and provider using their electronic care recording system.
● Equipment and the premises were managed safely. Safety checks were completed when required.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Good

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 remained the same. 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.

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

At the last inspection the provider's auditing systems were not robust enough to effectively monitor the quality of care provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17

● Quality monitoring systems were in place. Audits covered all key areas such as health and safety and infection prevention and control, and usually identified good practice, concerns and actions to drive improvement.
● Medicines audits had not highlighted shortfalls identified at the inspection such as insufficient information about how to apply some topical creams. The registered manager further developed their auditing process to ensure future issues were addressed.
● Notifications about significant events such as serious injuries had been submitted to CQC and showed appropriate action was taken in response.
● Some incidents had occurred between people who used the service and were correctly referred to the local safeguarding team. However, not all had been notified to CQC. The registered manager addressed this immediately when we brought it to their attention and introduced additional measures to ensure all notifications were submitted without delay. Retrospective notifications of the incidents were submitted to CQC and showed appropriate action was taken at the time of the incidents.

At the last inspection we recommended the provider consults national best practice guidance for creating an environment that supports people living with dementia.

Enough improvement had been made at this inspection and the provider met the recommendation.

● After the last inspection the registered manager responded by detailing to us environmental

improvements had commenced. These continued which included additional signage to help people see where they need to go.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people:

● People's experience at Summerfield House Nursing Home was positive. They told us staff and management were kind and caring. One person said, "They make us so comfortable and create a lovely atmosphere." A relative told us, "Couldn't be happier, I wouldn't want my wife to be anywhere else."

● People were consulted, felt listened to and were confident raising concerns. Resident meetings and quality assurance surveys had been limited due to COVID-19 restrictions; the registered manager said they had kept communication going throughout the pandemic and feedback from everyone confirmed this.

● The registered manager was engaging and knowledgeable about the service. One person said, "The manager is first class, he gets everything right." A relative told us, "I think it is very well managed and they are proactive, for instance, during the worse days of the pandemic they were lobbying to bringing on change rather than waiting for the government. The manager is very good." All staff we spoke with told us the registered manager was fair and approachable.

Working in partnership with others;

● The service worked collaboratively with others to benefit people using the service. Professionals such as the mental health team and falls prevention team were involved in people's care.

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 Medicines management was not safe which placed people at risk of harm.