

Bondcare (Halifax) Limited

# Summerfield House Nursing Home

## Inspection report

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Date of inspection visit:  
17 May 2022  
23 May 2022

Date of publication:  
15 July 2022

## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

### About the service

Summerfield House Nursing Home is a care home providing nursing and residential care to up to 107 people. The service provides support to people aged 65 and over. At the time of our inspection there were 94 people using the service. The home accommodates people across three separate units, each of which has separate adapted facilities. One of the units specialises in providing care to people living with dementia.

### People's experience of using this service and what we found

We found systems for managing medicines were not always safe. Staff did not order medicines in a timely manner. There were no robust processes for the administration of covert medicines and medicines administered via a stomach tube (PEG). There were audits of medicines management, but these were not sufficiently robust to identify issues affecting people's safety. Management did not always act in a timely manner to address medicine concerns when they were identified. As a result, people did not always receive their medicine as prescribed.

Staff understood how to manage risks to people and knew the processes to follow to manage any allegations of abuse. Recruitment processes were robust. Infection control practice met current requirements and staff wore PPE appropriately.

Healthy lifestyles were promoted, and systems were in place to make sure people's health needs were met. Menu planning met people's dietary needs and took into account individual and cultural preferences. Dependency assessments had been regularly carried out to ensure staffing levels met people's needs. Staff had the skills and knowledge to deliver care effectively. The environment was well maintained and designed to meet people's needs.

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 Provider's quality management systems had not identified some of the issues we found during the inspection.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection and update

The last rating for this service was requires improvement (published 22 September 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

### Why we inspected

We received concerns in relation to the management of medicines. We also took the opportunity to review other key questions that had previously been rated requires improvement. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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 not changed. 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](http://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 section of this report. You can see what action we have asked the provider to take at the end of this full report.

### Enforcement and Recommendations

We have identified breaches in relation to managing medicines safely and the good governance of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

### Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

Details are in our effective findings below.

**Good** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# 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

The inspection was carried out by three inspectors, a medicines 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.

#### 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

#### Notice of inspection

This 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 and professionals who worked with the service. 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 spoke with eight people who used the service and eight relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager, nurses, senior care workers, care workers, kitchen staff and activities coordinators.

We reviewed a range of records. This included 11 people's care records and multiple medicine records. We looked at five staff files in relation to recruitment and a variety of records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

# 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. 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

- Medicines management was not always safe which placed people at risk of harm.
- Medicines were not always available when they needed to be administered. People missed their medicines, including critical medicines and long-term antibiotics. One person told us, "Sometimes they haven't got certain medications and I have to wait for them to come in."
- Time specific medicine was not always given on time or in line with guidance. We found one person had been given an overdose of paracetamol.
- When people were prescribed medicines on an 'as required' basis, protocols were in place to inform staff how and when to administer them, however, staff did not always record the reasons for administering these medicines.
- Some people needed their medicines administered covertly (when a medicine is hidden in food or drink). Medicines records were not always clear when people required their medicines covertly and how this should be done. This could lead to people being given their medicines in an inappropriate way.

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.

We spoke with the provider about the immediate concerns we observed, and the provider acted appropriately. We noted there was no impact of harm on people.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

### Systems and processes to safeguard people from the risk of abuse

- The provider had systems and policies in place to safeguard people from the risk of abuse.
- Staff were provided with training in safeguarding and knew how to identify and report concerns.
- People felt safe living at the service. One person said, "I feel safe; there are always plenty of people around."

### Assessing risk, safety monitoring and management

- There was regular maintenance and servicing of fire safety systems, gas, electrical systems and equipment. Fire testing took place regularly and the fire exits were clearly marked and accessible.
- The registered manager reviewed accidents and incidents and used opportunities to learn from these.

- People had individual risk assessments in place. Where risks were identified these were highlighted within care plans. Staff understood people's risks.

#### Staffing and recruitment

- Staff recruitment records confirmed pre-employment and identity checks were completed before a new staff member began to support people. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- The provider told us they had experienced difficulties recruiting staff. This resulted in an increased use of agency staff to cover shortfalls in staffing levels.
- Staffing levels were allocated in line with the service's dependency tool, which was a system to determine how many staff were required per day to support people safely.

#### Preventing and controlling infection

- Infection control was managed well, and the home was clean.
- Staff received infection control training and followed safe practices around washing hands and wearing personal protective equipment (PPE) appropriately.
- The provider was facilitating visits for people living in the service in accordance with the current guidance.

#### Learning lessons when things go wrong

- Opportunities to identify lessons learnt, such as through complaints and accidents, were shared with staff. However, staff said they felt supervisions could be done more frequently so that issues could be discussed in more detail.
- The registered manager took action to address people's concerns and documented outcomes.

# 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 requires improvement. At this inspection the rating has changed to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs

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

- The building was designed appropriately, to enable people to have as much independence and personal freedom as possible.
- Consideration had been given to ensuring the environment on specific units was suitable for people living with dementia.
- A relative told us, "Staff managed to get [my relative] a chair so she can go into the dining room. Prior to coming to Summerfield House, she was bed bound."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments had been completed prior to people moving into the service. These helped ensure the environment was suitable and staff could meet people's needs.
- People, and where appropriate, their relatives were included when assessments were completed.
- People we spoke with said staff were good at promoting choice.

Staff support: induction, training, skills and experience

- Staff had completed an induction programme to ensure they had the skills to care for people.
- Staff competencies were checked to ensure they were supporting people safely.
- One staff member told us, "We get plenty of training here; it's available online, and there are practical courses as well, such as moving and handling."
- People said they thought staff were skilled, competent and knew how to look after them.

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

- Staff understood when people needed support with eating and drinking.
- Special dietary requirements were accommodated by the provider including any medical or cultural needs.
- Care plans detailed where people needed modified diets. However, there were some gaps in staff guidance. These were addressed with the registered manager on the day of the inspection.
- One relative said, "[My relative] had a dietary plan for weight loss but eats and drinks really well now. Staff

encourage her and she always has assistance. Staff are well trained in care and very aware of how to deal with dementia."

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support

- People were happy with the support they received with their healthcare. One person said, "If you are not well the nurse will come and you are seen to straight away."
- Staff monitored, identified and recorded changes in people's health and made appropriate referrals to health professionals.
- Care records showed a wide range of health and social care professionals were involved in people's care and any advice given was acted upon.
- Oral care was provided in line with people's needs and wishes. People had access to dentists when required.

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 followed the principles of the MCA. People were asked for their consent before any support was provided and their rights were respected. DoLS were requested appropriately.
- One relative said, "[My relative] says they are very kind to her. They treat her with dignity and respect, they use her name, ask for consent to care and chat as they are doing things. They knock before coming in her room and pull the curtains if doing anything personal with her."
- People told us they did not feel restricted. Staff said they understood their role in protecting peoples' rights. One staff member said, "We support people to do as much for themselves as they can and to help people make choices."

# 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 good. At this inspection the rating has changed to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The auditing systems for medicines were not used effectively in monitoring the safety of medicine administration processes to identify risk.
- Quality monitoring checks did not lead to actions to address issues raised. For example, out of stock medicine concerns were not addressed in a timely manner.
- We reviewed the quality systems for safeguarding, complaints, and incidents and found that relevant actions were followed up appropriately, in line with the providers quality audit processes.

Systems and processes to monitor the safety and quality of medicine administration were not robust. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Continuous learning and improving care

- The registered manager told us they sought feedback from people and relatives to ensure they were continuously improving the service.
- The provider encouraged staff to continue their learning. Staff told us they had opportunities for development and their achievements were recognised.
- People spoke positively about the registered manager. One person told us, "The registered manager is personable, I have no worries speaking to him. He delegates work to the nurses who are always on the floor and you know where to find them. They seem really competent."
- Feedback from health professionals was positive. One health professional we spoke with said, "We find the management team to be responsive and receptive; they are happy to take feedback following our visits."

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

- The provider and registered manager demonstrated a commitment to provide person-centred care by engaging with people using the service.
- People we spoke with were happy with the way staff treated them and told us staff were kind, caring, treated them with dignity and respect, and helped them maintain their privacy. One person told us, "It's definitely well managed, the staff are pleasant. The boss is a decent man, a friendly person and if you are in trouble, he will help you out. He breeds a good atmosphere; you feel easy with him." One relative said, "There are a lot of people around and lots of activities to stimulate people. You wouldn't have to move

people if they required nursing care. It's nicely equipped [for example, the sensory room]. There are a lot of pluses."

- People told us the registered manager was helpful, listened to them and was visible. One person said, "You can always speak to him, he's very nice, you see him about. He's very efficient, if you want to talk to him, he'll be there."

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 registered manager understood their responsibility to be open and transparent and informed people, relatives and relevant professionals and organisations when things went wrong.
- One relative said, "If any issues arise, we raise them, and we are listened to; any changes needed are agreed and implemented."

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

- Systems were in place to ensure inclusive activities were planned that were meaningful to the people participating in them.
- The provider used surveys to seek people's views about the service to inform future improvements. One relative said, "We are happy with the care. Staff are only too happy to help."
- One person said, "I would recommend [Summerfield House] because there is no bias here everyone is treated fairly and equally."

Working in partnership with others

- The provider worked in partnership with other services and had positive community links.
- Staff told us about links with the local library that had set up a book delivery service which allowed people to request books to read.
- One health professional said, "The provider is working with us to recover from the effects of the pandemic. The registered manager works hard to complete the actions we require of him and always responds to us in a timely manner."

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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<ul style="list-style-type: none"><li>• The auditing systems for medicines were not used effectively in monitoring the safety of medicine administration processes to identify risk.</li><li>• Quality monitoring checks did not lead to actions to address issues raised.</li></ul>

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
Treatment of disease, disorder or injury	<ul style="list-style-type: none"><li>● Medicines management was not always safe which placed people at risk of harm.</li><li>● Medicines were not always available when they needed to be administered.</li><li>● Time specific medicine was not always given on time or in line with guidance.</li><li>● When people were prescribed medicines on an 'as required' basis, protocols were in place to inform staff how and when to administer them.</li><li>● Medicines records were not always clear when people required their medicines covertly and how this should be done.</li></ul>

### **The enforcement action we took:**

Warning Notice