Bondcare (Halifax) Limited

Summerfield House Nursing Home

Inspection report

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16 January 2024
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08 February 2024

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09 April 2024

Ratings

Overall rating for this service	Inadequate

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

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. Oak provides residential care, Cedar specialises in providing care to people living with dementia and Maple provides nursing care. There were 94 people living at Summerfield House when we inspected.

People's experience of the service and what we found:
People were at risk of harm as the provider had not always identified, assessed or mitigated risks. Systems in place to manage medicines were unsafe which placed people at risk of harm. There were not always enough staff to meet people's needs and keep them safe. Staff were not always appropriately deployed and training was not kept up to date. Recruitment processes were not robust.

People were not always treated with dignity and respect. Staff were not always caring. Some staff were task focused, lacked empathy and did not communicate with people when providing support. People were not always protected from the risk of abuse and improper treatment. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in place did not support this practice.

Care was not person-centred, and people's needs and preferences were not always met. The culture of the service was not person-centred. Systems and processes had not identified, or resolved in a timely manner, concerns around person-centred care, safeguarding, medicines and dignity and respect. The provider's systems and processes were not established or operated effectively to ensure continuous learning and the improvement of the quality of care.

People's care records were variable. Some had detailed and personalised information, whereas others were not always accurate and up to date. The environment was clean and well maintained. Infection control was well managed. People were supported to stay in touch with friends and relatives and there were no restrictions on visiting. People had access to healthcare services.

Feedback from people and relatives was generally positive describing staff as good and helpful. Some individual staff were noted to be exceptional and said to go 'above and beyond'. We also saw staff who did treat people with respect and maintained people's dignity.

The provider took action during and after the inspection in response to the concerns we raised. An action plan has been put in place and additional senior management have been brought in to support the staff team. The local authority and ICB continue to work with the provider to make improvements.

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 9 November 2023). There was 1 breach of regulation and 3 recommendations. At this inspection we found the provider remained in breach of regulation.

Why we inspected
The inspection was prompted in part due to concerns received about the management of the home, care and treatment and privacy and dignity. A decision was made for us to inspect and examine those risks.

The inspection was also prompted in part by notification of incidents where people's safety, health and well-being had been put at risk. These incidents are subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of risk. This inspection examined those risks.

We undertook a focused inspection to review the key questions of safe, caring and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

Enforcement
We have identified 6 breaches in relation to safe care and treatment, privacy and dignity, safeguarding, staffing, recruitment and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up
We will 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well-led findings below.	**Inadequate**

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.

Inspection team
Four inspectors and 2 Experts by Experience visited on 16 January 2024. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Two inspectors and a senior specialist visited on 24 January 2024. Two inspectors undertook a night visit on 25 January 2024 and 2 inspectors visited on 5 February 2024. A regulatory co-ordinator made phone calls to staff.

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 a registered manager in post. However, the registered manager resigned and left on 7 February 2024 and an interim manager is now in place.

Notice of inspection
The inspection was unannounced. Activity started on 16 January 2024 and ended on 8 February 2024. All site visits to the service were 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 quality and safeguarding teams. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does 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 20 people who used the service and 18 relatives/friends about their experience of the care provided. We spoke with 42 day and night staff including the registered manager, regional managers, deputy manager, unit managers, nurses, care staff, laundry and catering staff. We spoke with 4 visiting professionals.

We reviewed a range of records. This included 18 people's care records and 15 medicine records. We looked at 7 staff recruitment files. A variety of records relating to the management of the service were reviewed.
We provided feedback to the registered manager and/or regional manager when we visited on site and at the end of the inspection.

Inadequate

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. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection risk management processes were not robust which meant people were not always protected from harm or injury. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvements and the service remained in breach of the regulation.

● Risks were not always identified or acted upon by the provider or staff. Pressure relieving equipment was not set up correctly posing a risk of skin damage to people. Care records showed repeated occasions where staff had been physically assaulted by people who were distressed. Incident and accident forms were not always completed. The risks to staff and others had not been fully assessed, managed or reviewed to prevent recurrences.
● Risks to people's health were not managed safely or consistently placing them at risk of harm or injury. Information about risks were not always passed on to staff. This included specialist dietary requirements and weight loss management.
● Fire safety risk were not assessed and managed safely as there was no documentary evidence to show the night staff had participated in fire drills. Fire drills support staff to know what to do to keep people safe in the event of fire.
● Lessons learned from incidents was not always acted upon. At our last inspection we identified concerns relating to incident and accident reporting and the management of risks from people who were distressed. These had not been addressed at this inspection.

Risks to people were not always assessed and managed placing them at risk of harm. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They said action had and was being taken to address these issues. We will assess these actions at a future assessment.

Using medicines safely
● Medicines were not managed safely. Records for adding prescribed thickening powder to drinks, for people who have difficulty swallowing, were inconsistent and not always completed. Therefore, we could not be assured people were safe from the risk of choking.
● Information to support staff to safely give 'when required' medicines was not always in place, lacked detail or contained incorrect information. This meant there was a risk people might not have got their medicines when they needed them.

● Records showed medicines were not always available in the home to be given to people which placed them at risk of harm.
● When people had their medicines covertly, hidden in food or drink, information to support staff to safely give medicines this way was not always available in the medicines administration records or care plans. Therefore, we were not assured that people were given their medicines safely.
● We found the site of the application of medicine patches were not always rotated in accordance with the manufacturer's instructions and the location of the patch was not always recorded. This meant people were at risk of skin irritation.
● Training records for staff authorised to give medicines were inaccurate and not up to date. We were not given assurance that staff had had their competency to administer medicines safely recently checked.

We found medicines were not managed safely. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and advised they were taking action to address these issues. We will assess these actions at a future assessment.

Staffing and recruitment

At our last inspection we recommended the provider reviewed dependency levels and staff allocations to ensure people's needs could be met at busy times of the day and taking into account the layout of the home. At this inspection the provider had not made sufficient improvement.

● The provider did not ensure there were sufficient numbers of suitable staff. We observed the care and support provided and found people's basic needs were not always met. Staff response to people's immediate need for assistance was not always timely. On several occasions, inspectors had to intervene and ask staff to assist people.
● Staff deployment was not effective in ensuring people received high quality person-centred care. Care and support delivery was task based with the computerised care system allocating staff tasks to be completed at a certain time. Staff said this meant they were often rushing which resulted in some people waiting longer for support. The layout of each floor with different communal areas, bedrooms, bathrooms and toilets extending down 3 corridors also impacted on staff's ability to respond promptly. We observed staff often struggled to support people who chose to stay in their rooms and meet the needs of those who were in communal areas.
● Feedback from people and relatives was mixed. Comments included; "Have to wait when you ring the call bell, can be up to 25 minutes. Happens a lot, staff congregate near the dining room, don't come in and spend time with [family member]"; "Have been very short of staff but seem to be doing okay at the moment" and "Response to call bell varies, sometimes have to wait a while, other times okay."
● Staff felt there was not always a team approach as some staff would support others if their own work was completed but other staff did not. Some staff also raised concerns about being moved onto different floors and the impact this had on people's care due to a lack of consistency, loss of trusted relationships and knowledge of how people communicated. This particularly affected people who had a protected characteristic, such as people living with dementia and those with complex needs because they may not be able to verbally communicate their needs and preferences.
● Staff were not up to date in safety related training. The training matrix identified several staff who required urgent training in several safety areas including safeguarding, fire safety, infection control and health and safety.

We found there were not always sufficient staff deployed to meet people's needs and keep them safe. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They increased the staffing levels and brought in additional senior managers to support the staff team. We will assess these actions at a future assessment.

The provider did not always operate safe recruitment processes.
● We reviewed 7 staff recruitment records and identified shortfalls in 2 of the records. One staff member had not completed an application form; a CV had been provided but contained no names or details of their employer. These issues had not been explored at interview. References were obtained but there were discrepancies between them and the information provided in the CV which had not been followed up. Another staff member's interview record was not fully completed, and it was not clear who had carried out the interview as the record was not signed. An interview questionnaire had been completed but was not dated or signed. All the recruitment records we checked had DBS checks and references completed.

We found robust recruitment checks were not always followed which placed people at risk from staff who may be unsuitable and unsafe. This was a breach of regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and advised they were taking action to address these shortfalls. We will assess these actions at a future assessment.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection we recommended staff training and knowledge for making and recording best interest decisions was reviewed and implemented. At this inspection the provider had not made sufficient improvement.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (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 provider was not always working in accordance with the Mental Capacity Act. The service had legal authorisations in place to deprive a person of their liberty. Nine authorisations had conditions in place which needed to be met to reduce the level of restriction on people. However, there was no evidence to show there were any checks in place to ensure the conditions were being met.
● Some best interest decisions had been completed where people lacked capacity to make their own decisions such as the use of monitoring equipment. However, there were restrictions in place, such as the use of bed rails, which had not followed this process. The training matrix showed only 77% of staff had

completed up-to-date training in MCA and DoLS.

We found the provider did not have effective systems in place to ensure the service was working in accordance with the MCA . This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Further information about the breach of regulation 17 is discussed in the well-led key question below.

The provider responded after the inspection and advised they were taking action to address these issues. We will assess these actions at a future assessment.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
● People were not always protected from the risk of abuse. We identified safeguarding concerns during the inspection, which we reported to the local authority safeguarding team. These concerns related to care practices and had not been identified by the management team. This meant the provider did not have an effective system to prevent, or respond to, the risk of abuse.
● The provider had not supported a person to get out of bed every day as they wanted to because they had to share a specialist chair with another person and take it in turns. This meant they were restricted to multiple days in bed each week. this demonstrated a rights-rejecting culture at the service. Following our feedback at the inspection, the provider supplied a second chair.

People were not protected from abuse and improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection and confirmed actions they had and were taking to address these issues. We will assess these actions at a future assessment.

● Staff understood safeguarding procedures although the training matrix showed only 75% staff were up to date with training.
● Records showed safeguarding incidents the provider had identified had been reported to the local authority and CQC.

Preventing and controlling infection
● People were protected from the risk of infection as staff were following safe infection prevention and control practices.
● Good standards of hygiene and cleanliness were maintained. Staff wore PPE appropriately. People said their rooms were kept clean.

Visiting in Care Homes
● People were able to receive visitors without restrictions in line with best practice guidance.
● People were supported to keep in touch with friends and relatives. Relatives were happy with visiting arrangements and said they were able to visit at any time.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- We found shortfalls and inconsistencies in the caring attitude of staff. Our observations showed some staff who were task focused, lacked empathy and did not communicate with people when providing support. For example, we saw people being moved in their chairs by staff without any prior explanation or discussion. We saw staff not responding to people who were emotionally distressed and calling out. We saw staff remove a person's cap, put an apron on them and spoon food into their mouth without any communication. We heard staff refer to people by their room numbers. One person told us, "Staff don't listen to me. I know what I want to wear but they ignore me. They think they know best." Another person said, "Some staff are more caring than others, but then we all have off days, don't we?"
- Staff did not always recognise people's changing needs or take steps to ensure they were met. For example, not picking up on distressed emotions which indicated a person was in pain and unwell, instead assuming it was their normal behaviour pattern.
- People's personal histories and cultural needs were not always recorded. One person's care plan stated English was not their first language. Records showed the person was often distressed and emotional. There was no information about the person's language or culture to help staff understand how to support them in a person-centred way.

People were not always treated well treated and supported. This was a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always respected by staff. On 2 separate occasions we saw a person using the toilet with the door wide open, exposing them to other people and staff who were walking past. When we raised this with staff they were unconcerned and said the person always did it.
- Staff did not always understand or respect people's right to confidentiality. We saw a staff member hand a mobile phone to a person whose relative wanted to speak with them. The person was sat in a communal area with others. The staff member did not ask the person if they would like to go somewhere private. The person had to take the call with other people hearing the conversation.
- We saw some people had stickers on their clothes with room numbers written on. Management told us relatives had put these in place, however, laundry staff confirmed they used iron on stickers which they wrote room numbers on rather than initials.
- We saw the people on the nursing floor were crammed into a small lounge, whilst other communal areas were empty. Some relatives told us they had raised concerns about the cramped conditions, but no action

had been taken. The minutes from the relatives meeting in December 2023 confirmed this.

People were not always treated with dignity and respect. This was a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and advised they were taking action to address these issues. We will assess these actions at a future assessment.

● Feedback from people and relatives was generally positive describing staff as good and helpful, there was also mention of staff who went above and beyond. We also observed staff who were patient, gentle and kind, listening to people and explaining what was happening. We also saw staff who did treat people with respect and maintained people's dignity. We observed people enjoying some activities and one-to-one time. However, we also received feedback from people who said they were bored. Comments included; "They do have some activities, like bingo, but it is limited and not for me" and "I don't really do much in the day. Just sit in the lounge really."

Supporting people to express their views and be involved in making decisions about their care
● People were not always supported to be involved in making decisions about their care. There was limited information recorded about discussions with people and their relatives. We received mixed feedback from people and their relatives about communication. Some people said they were kept informed, whereas others felt communication could be improved. Comments included; "Communication is good, staff update us and we get a monthly update"; "Communication is the biggest issue but this might be getting better with more staff" and "Communication is there but not always great." One relative said, "I would like to be able to speak with a member of staff who really knows [my family member] when I visit or call the home." This was echoed by other relatives we spoke with.
● Several relatives told us they often found it difficult to get through on the phone and sometimes hard to get hold of management.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- We found widespread and significant shortfalls in the management and provider oversight of the service.
- The provider failed to implement and operate effective risk management systems and to assess, monitor and mitigate risks to people. We identified regulatory breaches relating to medicines, staffing, safeguarding, recruitment, dignity and respect and assessing, monitoring and mitigating risks to people's safety. The provider had not identified these.
- The provider's systems and processes were not established or operated effectively to assess and monitor the service, and to ensure continuous learning and the improvement of the quality of care. Accident and incident forms were not always completed, and analysis of accidents was limited to falls. Analysis of other incidents where people were displaying distress was not completed. This meant understanding triggers could not be identified and people were living in distress without support.
- There was a lack of effective communication between management and staff. Handover records were not always accurate and some had very limited information which meant staff were not always informed of important changes or updates about people's needs. Staff who were providing one-to-one support were not included in handovers. A private WhatsApp group was used by staff to exchange information. The regional manager assured us this was only used to share information about rotas and no confidential personal information was included.
- The registered manager was not always notifying the local authority and CQC when things were identified to have gone wrong. For example, safeguarding concerns raised by the speech and language therapy (SALT) team with senior staff regarding a person who was given inappropriate food which placed them at risk of choking. This was not reported by the provider to the local authority or CQC.
- The provider had not created a learning culture at the service so people's care was not improved. The service has been rated requires improvement at the previous five inspections. Improvements the provider made in response to regulatory breaches had not been sustained.

The provider's systems and processes were not established or operated effectively to assess and monitor the service, and to ensure continuous learning and the improvement of the quality of care. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The culture of the service was not person-centred and did not always achieve good outcomes for people. We identified multiple examples of people not receiving care that was based around their individual needs and of people not being treated with dignity and respect. Systems and processes in place had not identified these issues or taken steps to resolve them in a timely manner. this meant there was a rights-rejecting culture at the service.

● People's care records were not always complete, accurate and up to date.

Systems and processes had not identified or resolved in a timely manner concerns around person-centred care, safeguarding and dignity and respect.
This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider responded during and after the inspection confirming actions they had and were taking action to address these shortfalls. Additional management resources were brought into the service to support the staff team and make improvements. The management team appeared committed to improving the service and an action plan was in place. The service was also receiving support from the local authority and ICB. We will assess these actions at a future assessment.

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

● Residents and relatives meetings were held. However, it was not always clear what action had been taken in response to issues raised and suggestions made at these meetings.

● We received positive feedback from some people and relatives. Comments included; "I am happy here. I feel safe and staff are nice"; "Since being here [family member] has improved a lot. I feel they look after her well" and "We're happy with the care, all the staff are lovely and helpful. It's better than where she was before."

● Care records showed the involvement of health and social care professionals in people's care. Health care professionals we spoke with during the inspection gave mainly positive feedback. However, concerns were raised by one professional regarding the care being provided to two people. We shared these concerns with the management team who assured us they would address these issues.