Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Summer Court

Football Green, Hornsea, HU18 1RA

Tel: 01964532042

Date of Inspection: 18 June 2013

Date of Publication: July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Hexon Limited
Overview of the service	Summer Court Hall is a care home that provides personal care and accommodation for older people, including those with dementia related conditions. The home is situated in Hornsea, a seaside town in the East Riding of Yorkshire. Most private accommodation is provided in single rooms and communal space includes an enclosed garden and enclosed courtyard. There are car parking facilities for visitors and staff.
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 June 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider, reviewed information sent to us by commissioners of services and talked with commissioners of services.

What people told us and what we found

We spoke with the area manager, the manager, a nurse, two care workers and two people who lived at the home as part of this inspection.

The people who lived at the home told us that they were happy living there. They felt that they received the support they needed and that they had good rapport with staff. One person said, "Staff are very good – they help us when we need it and there is some banter between us". We observed positive interactions between people who lived at the home and staff on the day of the inspection.

There had been a number of safeguarding investigations at the home since the previous inspection. These had resulted in a number of recommendations for improvement being made by the safeguarding adult's team. We saw that action had been taken by the organisation to improve practices at the home and that further training and supervision had been provided for staff, particularly around the areas of communication, recording and the administration of medication.

We saw that safe recruitment and selection processes were followed when new staff were employed. There were sufficient staff on duty but we noted that there were no domestic or laundry staff employed at weekends. This meant that nurses and care staff had other duties to perform in addition to providing care to people who lived at the home.

There were appropriate quality monitoring systems in place although there had been some delays in utilising these due to the transition to nursing care.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care and support that met their needs and protected their rights.

Reasons for our judgement

Peoples' needs were assessed and care was planned and delivered in line with their individual care plan, and in a way that ensured people's safety and welfare.

We spent some time observing interactions between staff and people who lived at the home in the dementia unit and spent time sitting with people in the residential unit. We saw positive interactions taking place. Staff engaged people in conversation and were seen to understand people's individual needs and to respond to them appropriately. People who lived at the home told us that staff were attentive and that they received support when they needed it. One person said, "Staff are very good – they help us when we need it and there is some banter between us".

We saw a variety of activities taking place on the day of the inspection. An organist visited the home in the afternoon and staff encouraged people to take part in the activity. One person told us, "The manager has been good – she has organised for me to do some gardening". In the dementia unit we saw that staff spent time with people, either talking to them or playing games with them. We saw that staff engaged with people on an individual basis in both units.

We checked the care records for one person who lived at the home and one person who had previously had respite care at the home. We saw that the information gathered at the time of a person's initial assessment had been incorporated into an individual plan of care. The provider may wish to note that some sections in the 'old' style care plans had not been completed. There was evidence that some people, but not all, had been involved in the development of their care plan, such as visits to their home prior to admission and the signing of consent forms.

Care plans included the use of risk assessments to determine a person's level of risk; these were for moving and handling, infection control and food hygiene. More individual risk assessments had been completed for some people, for example, the risk of skin damage, risk of injury when using the hoist, and burns and scalds.

One person needed to be turned on a regular basis to prevent pressure sores from developing. We checked the monitoring charts and found that recording on these was consistent. Appropriate equipment had been obtained such as pressure care mattresses and cushions. This person also was assisted with eating, drinking and taking medication by percutaneous endoscopic gastrostomy (PEG) feeding. There were specific details in the care plan about how the PEG should be used and checked to ensure it was working safely, including how to clean the tubes when needed.

We saw that assessment and care planning information included sufficient detail to inform staff how the person wished to be assisted or supported. For example, "Staff to approach me on my left side". Information about a person's family history, their personality, their likes and dislikes and their routines prior to their admission to residential care were included.

Care plans had been reviewed on a regular basis and any changes in a person's care needs had been added to their care plan. Details of contact with health care professionals had been recorded, including the reason for the contact and the outcome; in many instances these records had been made by the health care professional at the time of their visit. Correspondence from health care services had been retained with care planning documentation.

We saw that accidents and incidents had been recorded appropriately and that the use of body maps had improved. These had been signed and dated by staff so that there was a record of when injuries had taken place, the area of the body that had been affected and any action that had been taken by staff. This helped staff to monitor a person's improvement and deterioration in health.

Care files included a patient passport. These are documents that people can take with them to health care appointments and admissions to inform medical staff of their individual needs when they are not able to communicate this information verbally.

We saw that best interest meetings and the mental capacity two-stage test had been used to determine a person's capacity to make decisions and to assist people who lacked capacity to make decisions.

We checked an additional care plan for someone who was due to have respite care at the home. We saw that a care needs assessment had taken place prior to their admission. This included a dependency assessment that identified whether a care plan was needed for each area assessed. Information that was already known about the person had been incorporated into a care plan and information about the person's medical history and specific details about assistance with mobility had been recorded.

Some improvements had been made to communication at the home since the recent safeguarding investigations. Staff told us that they carried a notebook with them so that they could note any issues that needed to be shared with other staff and we saw that a communication book had been introduced to aid the sharing of information between nurses and care workers. Staff told us that communication had improved during the previous few weeks. In addition to this, a form had recently been introduced to the front of each care plan for staff to record when they had read the content. This helped staff to have up to date information about the people they were supporting.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The provider responded appropriately to any allegation of abuse.

The manager told us that the organisation considered safeguarding adults from abuse to be mandatory training and that most staff had completed training on safeguarding adults from abuse with the local authority. We were not able to confirm this by checking the training matrix on the day of the inspection.

The manager told us that three staff were booked on training specifically designed for managers of care services in July, and a further two people were booked on the training in September.

We spoke to two members of care staff and they displayed a good knowledge of the action they needed to take if they observed poor practice or became aware of an abusive situation. Staff told us that they worked well as a team and they felt that all staff were confident enough to speak to someone more senior if they observed any inappropriate practice.

Staff said that they felt any information shared with the home manager or other managers within the organisation would remain confidential and would be dealt with appropriately and professionally.

There had been some serious safeguarding incidents at the home since January 2013. The CQC had been informed of the outcome of these investigations by the safeguarding adult's team, and most had been substantiated. We were aware that a large number of recommendations had been made by the local authority following these investigations. Discussion with the manager and area manager indicated that the home acknowledged their failures in respect of these safeguarding investigations and had taken action to improve. Appropriate disciplinary action had been taken with staff as a result of the safeguarding outcomes.

Staff told us that the provider had visited the home to hold two meetings following the

outcome of the safeguarding investigations, one with nurses and one with other staff. The meeting with the nurses had included further training on recording and communication between nurses and care staff. Staff told us that communication between nurses and care workers had improved and we were shown examples of this on the day of this inspection. In addition to this, all nursing staff had completed training on body mapping, pressure care, care plans/evaluations and enteral feeding, and one nurse had completed training on the use of syringe drivers.

We saw that accidents and incidents had been recorded appropriately and this included the use of body maps to record any injuries, bruises or sore areas. Short term care plans were used to monitor new injuries noted. For example, one person had a short term care plan in place to monitor a blister on their eye. The provider may wish to note that this had not been recorded on a body map, although more recent injuries had been.

We did not check any monies held on behalf of people who lived at the home during this inspection.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Appropriate arrangements were in place in relation to obtaining medicine and medicines were kept safely.

The nurse on duty explained the arrangements for the storage, administration, recording and disposal of medication to us. Medication was stored in two trolleys; one for the dementia unit and one for the residential unit. These were stored in the locked medication room when not in use. There was a medication administration record (MAR) book for each unit and we saw that the medication policy was included in each MAR book.

We saw that medication had been supplied by the pharmacy in blister packs that were colour coded to identify the time of day they needed to be administered. These colour codes corresponded to information on the MAR charts.

We checked the storage of controlled drugs (CDs) and found that the cabinet met current guidelines. The cabinet was fixed to the wall in the medication room. We checked the records against a sample of medication held in the cabinet and found these to be accurate. The nurse told us that there were two staff signatures in the CD book to demonstrate that CD's had been administered and one signature for the same medicine in the MAR book, and we saw evidence of this on the day of our visit.

We checked MAR charts and found recording to be satisfactory, although the provider may wish to note that there were not always two signatures on hand written entries and there were occasional gaps in recording. The MAR charts recorded the person's name, date of birth, GP, any allergies and the dates that the MAR covered. There was a photograph of each person to accompany their MAR chart. We noted that MAR charts included information about a person's need for 'as and when required' medication and that the details of the amount of medication administered were recorded on the rear of the MAR chart. There were body maps to demonstrate where on the body creams needed to be applied.

We saw that some MAR charts recorded that medication had been discontinued and advised that more detailed information should be recorded, such as who had given this

advice and the date. The nurse showed us MAR charts from previous months and we saw that it was usual practice for additional information to be recorded.

There were more specific details included with some MAR charts. We saw that the arrangements to record the dose of Warfarin needed by people who had been prescribed this medication were satisfactory and that one person only needed to be given medication when their pulse was lower than 70; we checked the records on the MAR for this person and found them to be accurate.

Staff told us that they checked medication fridge temperatures daily to ensure that medication was being stored at the correct temperature. We saw there were occasional days when the fridge temperatures had not been recorded but that temperatures were within recommended guidelines. The provider may wish to note that the recording of the temperature in the medication room had ceased.

The manager told us that only nurses administered medication and that they had completed appropriate training. The manager told us that additional training had been arranged via the home's pharmacy supplier; some had taken place on 6 June and a further day had been booked for 13 June. We saw that competency checks had been carried out with nursing staff on the administration of medication and that these checks had been recorded.

The nurse told us that prescriptions were being photocopied so that they could be cross referenced with medication when it was delivered by the pharmacy. They explained the arrangements for returning medication to the pharmacy and we checked the records of returned medication. This included the person's name, their date of birth, the name of the medicine and the quantity of medication returned. The record had been signed by a member of staff at Summer Court and a member of staff from the pharmacy. Medications were disposed of appropriately.

Staff told us that unused medication was returned to the pharmacy every month and a new supply delivered each month. This meant that the home did not need to store large quantities of medication. In addition to this, staff did not need to record on packaging when they started to use the medicine, as a new pack was used each month.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

Appropriate checks were undertaken before staff began work.

We checked the recruitment records for a new member of nursing staff. We saw that an application form had been completed that recorded the person's education, employment history, knowledge/skills/experience, the names of two referees and a declaration that the person had no criminal convictions. The applicant had also produced a curriculum vitae (CV).

We saw that two written references and a Criminal Records Bureau check (now known as a Disclosure and Barring Service check) had been obtained prior to the nurse commencing work at the home. Information had been requested from the nurse to evidence that they were registered with the Nursing and Midwifery Council (NMC).

We saw that there was a record of the nurse's induction into the home. This included orientation to the service, a number of in-house training sessions plus competency checks on the administration of medication.

The manager told us that, following a recent safeguarding investigation, one of the nurses had been dismissed and referred to the NMC. This evidenced that appropriate steps had been taken in relation to a person who was no longer fit to practice.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

When we arrived at the home we saw that there were four staff on duty; a nurse and three care workers. This was to provide care for eighteen people who lived at the home permanently and one person having respite care at the home.

The staff rota evidenced that standard staffing levels were: one nurse on duty from 8.00 am to 8.00 pm and from 8.00 pm to 8.00 am. During the day, there were either 3 or 3.5 care workers on duty and during the night there was one care worker on duty. The manager was on duty, Monday to Friday, in addition to these staffing levels. The staff rotas evidenced that these staffing levels had been maintained.

The manager told us that one of the nurses currently worked at the home part time but they were due to become a full time employee.

Ancillary staff were employed in addition to nursing/care staff. There was a cook on duty each day and they were available to provide breakfast and lunch. This left care staff to prepare tea and supper. Domestic staff and a laundry assistant were employed on five days a week, Monday to Friday. The provider may wish to note that this allowed nursing and care staff to concentrate on supporting people who lived at the home from Monday to Friday, but that they had additional duties over the weekend that may have distracted them from providing individualised care.

There was no activities co-ordinator employed at the home but there was an entertainer at the home on the afternoon of our inspection and we saw staff engaging people in one to one activities.

We noted that there was a mix of male and female nurses and care workers employed at the home so that if someone who lived at the home had expressed a preference to be assisted by a care worker of a particular gender, this could be accommodated.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

Reasons for our judgement

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

There was a quality assurance calendar for the organisation that was in the form of a checklist to aid the manager; this recorded the activities that needed to take place and the frequency, for example, policies and procedures updated (6 monthly), staff appraisals (monthly) and resident meetings (3 monthly).

There had been a relatives meeting in March but only one relative attended. The manager said that she was considering ways to encourage more relatives to take part.

A staff meeting had been held in March 2013 and again in June 2013. We saw that whistle blowing, safeguarding investigations, daily reports, staff supervision, expectations from staff, company policies and 'the way forward' had been discussed. The provider may wish to note that we did not see any records of resident meetings. There was also evidence that additional staff supervision meetings had been taking place with the area manager and the manager following the safeguarding investigations to ensure that the recommendations of the safeguarding adult's team had been actioned. These focussed particularly on recording, communication, body mapping and the administration of medication.

In addition to this, the manager had observed each member of nursing or care staff whilst working with people who lived at the home. Staff were given feedback and the exercise had been used as an opportunity to identify additional training needs.

We saw the surveys that had been produced by the organisation. There were surveys for people who used the service, staff and relatives but these had not been distributed in 2013; the area manager said that this had been delayed due to the transition to nursing care. Surveys were due to be distributed in June 2013.

The area manager told us that surveys that had been distributed in previous years and we saw that the questions were designed to give people the opportunity to comment on the

quality of the service they had received. We noted that, in previous years, the responses to surveys had been collated and analysed. The area manager said that they had been shared with people who lived at the home and staff at meetings.

Various audits had been carried out, including those on cleaning schedules and the nurse call system. The manager told us that a medication audit had been completed by one of the nurses on 14 June but the records could not be found on the day of the inspection.

We saw that accidents and incidents had been recorded but we did not see any evidence that they had been analysed to identify patterns that had emerged or any improvements that needed to be made.

Monthly reviews of care plans had taken place; this ensured that staff had up to date information about each person who lived at the home so that they could provide appropriate care and treatment.

The home's complaints procedure was displayed in the entrance hall and the area manager told us that there was a copy in each bedroom. We checked the home's complaints log and noted that the last formal complaint had been received in November 2011. There was a record of the details of the complaint, details of the investigation and the complainant had signed to record that they were satisfied with the outcome. The people who we spoke with told us that they had no concerns and that they could speak to staff if they had a complaint or concern. They said that they were certain staff would try to alleviate their concerns if they could. Both of the people who we spoke with said, "The manager listens to us and tries hard to do what we ask".

The home's fire risk assessment had been updated in October 2012, monthly fire drills had taken place and weekly tests of the fire alarm system had taken place up to 5 June 2013. We noted that no test of the fire alarm system had taken place during week commencing 10 June but prior to that date they had been carried out consistently. These arrangements helped to protect people who lived at the home and staff from the risk of fire.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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