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 September 2012

Date of Publication: October 2012

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Safeguarding people who use services from abuse	✖ Action needed
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Hexon Limited
Registered Manager	Ms. Jane Brindley
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 service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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, reviewed information sent to us by other organisations, carried out a visit on 18 September 2012 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with staff.

What people told us and what we found

We spoke with four people who lived at the home. They told us that staff respected their privacy and dignity and that staff knocked on doors before entering their room. However, we found that there was a lack of privacy and dignity shown towards people who were accommodated in the dementia unit.

People told us that staff encouraged them to be as independent as possible and that they could choose how and where to spend their day. People told us that they liked the food provided at the home. One person told us, "I am on a low sugar diet but I still get nice food".

People told us that they liked the staff. One person said, "I get along with all of the staff - they are all pleasant and they make you feel comfortable". People told us that they liked living at the home but some people told us that they would appreciate being able to take part in more activities.

People were able to name a staff member who they would speak to if they had any concerns or wished to make a complaint.

We were concerned that care staff were not clear how to react to some safeguarding situations and, when the manager was not present at the home, how to make an alert to the local authority safeguarding adult's team.

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

What we have told the provider to do

We have asked the provider to send us a report by 01 November 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is

taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were not always respected.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Some people, but not all, expressed their views and were involved in making decisions about their care and treatment.

On the day of our inspection we checked the care plans for three people who lived at the home. We saw that care needs assessments had been completed that recorded a person's capacity to make decisions and included information that advised staff how to promote privacy and dignity. For example, '.... voice is quiet and staff should ensure they give him time to express his needs' and 'staff to remove unwanted facial hair when required'. The people that we spoke with told us that staff respected their privacy; they said that they used their preferred name and knocked on doors before entering.

Care plans also included information about what people could do for themselves and what they needed support with. One care plan that we saw recorded, 'Include .... in all aspects of his care and enable him to do things for himself where possible'. We saw that people living in the main area of the home were encouraged to be as independent as possible. The people that we spoke with confirmed that staff only assisted them with the tasks they found difficult.

People told us that they could get up and go to bed when they chose and that they could decide where to spend the day. One person that we spoke with told us that they preferred to stay in their own room and this was supported by staff. We saw lunch being served and noted that people were offered a choice of meals and drinks and that staff encouraged socialisation and interaction.

However, we also observed lunch being served in the dementia unit. We saw one member of staff assisting two people to eat at the same time. We saw that people were not offered a choice of meal and that there was no explanation from staff about the meal provided. We saw that one member of staff did not make eye contact with the person when they asked them if they had had sufficient to eat and it was clear that the person did not realise that

the staff member was talking to them. We observed that there was a lack of respect shown regarding people's dignity.

There was little evidence in care planning documentation regarding what action would be taken to assist people with decision making when they did not have the capacity to make decisions for themselves. The manager had undertaken some basic training on the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and was able to give us examples of when best interest meetings would need to be arranged. The care staff that we spoke with had little understanding of these concepts.

Two of the people we spoke with could not remember being asked if they were satisfied with the care provided but one person could recall being asked to complete a satisfaction survey. The provider may wish to note that there was a lack of evidence that people were involved in how the service was run.

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.

Most people experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs had been assessed and care and treatment was planned and delivered in line with their individual care plan.

We checked the care plans for three people who lived at the home. We saw that information gathered at the time of their care needs assessment had been used to produce an individual plan of care. Health and social care professionals and relatives had been consulted about the content of care packages and people had been asked to sign their agreement to care plans when they were able to do so.

Assessments and care plans included areas such as personal hygiene, mobility, isolation, continence, oral care, bathing, vision, social activities, communication and diet. Care plans recorded the identified need, the action required to meet the need and 'by whom'. These documents were supported by assessment tools for pressure care, moving and handling and dependency levels. The provider may wish to note that the dependency assessment did not include a scoring system. The manager was able to explain how dependency levels had been arrived at but it was difficult to ascertain how the assessment allowed for the overall dependency levels of people living at the home to be identified.

We saw that care planning documentation was reviewed each month and that care plans had been amended to reflect changes in a person's care needs. Social Services staff had undertaken a formal review of the care plan for one person in July 2012; the other people whose records were checked were either at the home for respite care or newly admitted so not due for a formal review. We noted that no audits of care planning documentation had taken place to check that monitoring tools such as food and fluid intake charts and other care planning documentation had been used consistently by staff.

We saw that contact with health care professionals had been recorded and that this information included the outcome of the contact; records had been signed and dated by staff. Daily reports were written by staff to record the actual care provided.

Patient passports had been completed, some in more detail than others. These are documents that people can take with them to hospital appointments or admissions to inform health care staff of their individual care needs.

There was an activity taking place in the main area of the home on the day of our inspection. However, the provider may wish to note that people we spoke with told us that they spent too much time watching the television as there were not enough activities on offer. We did not see any activities taking place in the dementia unit throughout the day. Although a musician visited the main area of the home, people accommodated in the dementia unit were not included. People were being watched to make sure they were safe but there was little interaction between them and staff, and people sat either looking around them or at the TV. Two of the three staff that we spoke with had completed training on dementia awareness but the provide may wish to note that they did not display the skills needed to involve people with dementia in meaningful activities.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and hydration.

Reasons for our judgement

People were supported to be able to eat and drink sufficient amounts to meet their needs. On the day of our inspection we observed the serving of lunch in the main area of the home. We saw that people were offered a choice of meals and drinks and were offered 'second helpings'. The cook told us that they spoke with people the previous day to ask which of the choices they would prefer, but that they always prepared extra in case people changed their mind. One of the people we spoke with was complimentary about the breakfasts prepared by the cook.

The cook explained how they prepared meals for people with special dietary needs, for example diabetes, and said that they tried to make their meals as appetising as everyone elses. They said that the manager told them about any special dietary requirements and that these were placed on the notice board in the kitchen. One person told us, "I am on a low sugar diet but I still get nice food".

Care plans included assessments regarding a person's dietary requirements and people were being weighed as part of nutritional screening. Where concerns had been identified regarding a person's nutritional intake or swallowing difficulties, referrals had been made to dieticians or speech and language therapists.

Training records evidenced that staff had undertaken training on food hygiene, healthy eating and the use of the Malnutrition Universal Screening Tool (MUST). We saw that there were food and fluid intake charts being used for people at risk of malnutrition, and that these were being maintained consistently.

We had some concerns about the assistance being provided with eating for people in the dementia unit. These have been addressed under outcome 1.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service were not fully protected from the risk of abuse. Although the provider had taken reasonable steps to identify the possibiity of abuse and prevent abuse from happening, staff were not clear about the action they should take even though they had undertaken training.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People who used the service were not fully protected from the risk of abuse. Although the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening, staff were not clear about the action they should take even though they had undertaken training.

The manager told us that she had undertaken training specifically designed for manager's of care services on safeguarding adults from abuse. This training had included references to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLs). She was able to explain how she had dealt with allegations of abuse or safeguarding concerns that had been brought to her attention and we were aware that she had previously sent safeguarding alerts to the local authority safeguarding adult's team for consideration.

The local authority safeguarding adult's team had recently undertaken an investigation. The outcome was inconclusive but one of their recommendations was that staff should record the two hourly checks they undertook during the night. We saw that this recommendation had been actioned by the home.

The manager said that all staff had undertaken training on safeguarding adults from abuse but this had not included information about the MCA or DoLs. Training records evidenced that staff had undertaken training on safeguarding. However, in discussions we had with staff they were able to explain some types of abuse but were unclear about what action they would take if they became aware of an incident of abuse or received an allegation of abuse. They told us that they would inform the manager but they were not aware of how to make a safeguarding alert in the manager's absence. They were also unclear about the need to immediately make sure that people living at the home were protected. This could have resulted in a delay in people being removed from the risk of harm.

On the day of this inspection we noted that there was a call bell in the lounge in the main area of the home. However, there was no call bell in the lounge in the dementia unit and

this could have resulted in staff having to shout to summon assistance from colleagues rather than being able to use the call system. The provider may wish to note that this could have resulted in a delay in people who lived at the home receiving the attention they needed, or a delay in staff receiving support to assist them in dealing with a potentially dangerous situation.

We asked the manager about accident and incident reporting. Records showed that there had been one accident since the last inspection in January 2012. The accident had resulted in a small skin tear for the person concerned and no medical intervention had been required. This incident did not require a notification to be submitted to the Care Quality Commission. However, we did see another incident report within care planning documentation and noted that this information had not been added to the accident and incident records shown to us.

We did not look at the arrangements for any monies held on behalf of people who lived at the home on this occasion. No issues had been raised about this aspect of safeguarding people from abuse.

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

Reasons for our judgement

There were usually enough qualified, skilled and experienced staff to meet people's needs. The manager told us that there were four care staff on duty throughout the day and two care staff on duty overnight, one on each unit. In addition to this, the manager worked from 8 am until 5 pm Monday to Friday. The manager said that there were four senior care workers employed at the home and that there was usually a senior care worker on shift in both units. The provider may wish to note that the role of staff members was not recorded on the staff rota so it was difficult to determine when senior staff were on duty. We checked the staff rota for the month of September and we saw that these staffing levels had been maintained.

In addition to care staff there was a cook on duty each day, a domestic assistant on duty from Monday to Friday and a laundry assistant on duty from Monday to Saturday. Care staff were responsible for domestic duties on Saturdays and Sundays and for laundry duties on a Sunday. This reduced the amount of time care staff had available to spend with people living at the home on these days.

We were concerned that dependency assessments had identified that some people required the assistance of two people to support them with personal care tasks. If people needed assistance during the night, there was the potential for both staff to be in one unit and no-one in the other unit. In addition to this, only one person in the dementia unit was able to use the call system and another had been provided with a pressure mat. Staff undertook two hourly checks to monitor that people were safe during the night but this may not have been often enough for people who were unable to summon assistance. The provider may wish to consider re-assessing the number of care staff employed during the night.

Complaints

✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available and comments and complaints people made were usually responded to appropriately.

Reasons for our judgement

People were made aware of the complaints system and this was provided in a format that met their needs. The manager told us that the home's statement of purpose included information for people on how to express concerns or make a complaint. The home's policy stated that verbal complaints would be responded to immediately and written complaints would be acknowledged within two working days and people would be notified of the outcome in 28 days. The policy also stated that complaints could be directed to the general manager, the director or the Care Quality Commission (CQC).

The manager told us that no verbal complaints had been received by the home during the previous six months. She said that people who lived at the home had a key worker but she believed that people would raise issues with any member of staff. She said that staff would raise issues in supervision meetings or at team meetings.

The people that we spoke with were able to name a member of staff who they would speak to if they had any concerns or wished to make a complaint. One person said, "I could tell the staff about any worries I had" and another person said that they had never had to complain but that they believed their complaint would be looked into.

We checked the complaints log and noted that the most recent complaint had been received in November 2011. The provider may wish to note that the complaint had not been dealt with as stated in the home's complaints policy. Although the complaint had been recorded, the documentation did not include details of the investigation, the letters sent to the complainant or the outcome.

We noted that there had been no audits undertaken to monitor whether the home's complaints policy had been followed when complaints had been received.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: People's privacy, dignity and independence were not always respected. (Regulation 17)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who use the service are not fully protected from the risk of abuse. (Regulation 11 (1))

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 01 November 2012.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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, 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 dentists, primary medical services and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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 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.
✖ **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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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.

Contact us

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