Sutton in the Elms Limited

# Sutton in the Elms

## Inspection report

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Sutton In The Elms
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29 September 2020

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## Ratings

| Overall rating for this service | Inspected but not rated |
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|---|---|
| Is the service safe? | **Inspected but not rated** |
| Is the service well-led? | **Inspected but not rated** |

# Summary of findings

## Overall summary

About the service
Sutton in the Elms is a 40-bedded residential care and nursing home. It specialises in the care of older and younger people who have needs relating to dementia, mental health, physical disability, and sensory impairment. At the time of our inspection there were 29 people using the service.

People's experience of using this service and what we found
Staff knew how to minimise risk to people and keep them safe, but improvements were needed to care records to ensure care was provided as planned. People did not always have care plans and risk assessments in place when they started using the service.

Some improvements were needed to the way medicines were managed to ensure records were complete and medicines safely stored.

There was enough staff on duty to meet people's needs. The service had a well-being strategy and provided staff with ongoing support and advice.

The premises were clean, fresh and tidy. All staff wore appropriate PPE (personal protective equipment). There were good systems in place to prevent and control the spread of infection.

Most people and relatives were satisfied with the quality of care provided. Some relatives said they would like better communications with the service, particularly regarding visiting arrangements.

The manager, who is currently applying for registration with CQC, was helpful and kind and people and relatives spoke highly of them.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Why we inspected
This was a focused inspection based on concerns we received about the service. We received concerns in relation to people's care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

This service was registered with us on 15 January 2020 and this was its first inspection. The last rating for the service under the previous provider was Good published on 17 December 2019.

We will continue to monitor information we receive about the service until we return to visit as per our re-

inspection programme. If we receive any concerning information we may inspect sooner.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sutton in the Elms on our website at www.cqc.org.uk.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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| **Is the service safe?**<br>The service was not always safe.<br>Details are in our safe findings below. | **Inspected but not rated** |
| **Is the service well-led?**<br>The service was not always well-led.<br>Details are in our well-led findings below. | **Inspected but not rated** |

# Sutton in the Elms

**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 and safety of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of an inspector, a specialist advisor, and an expert by experience. A specialist advisor is a person with professional expertise in care and/or nursing. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Sutton in the Elms is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager who no longer worked for the provider but had not de-registered with CQC. A new manager had been appointed who oversaw the day to day running of the service and had applied for registration with the Care Quality Commission. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced although we did contact the manager from the car park when we arrived to ensure it was safe for us to visit and that no-one at the service was unwell due to COVID-19.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about. We reviewed information received from the local

authority.

During the inspection
We spoke with three people using the service and one relative. We spoke with eight relatives by telephone. We spoke with the manager, deputy manager, operations director, the business well-being co-ordinator, a nurse, a care worker, an activities co-ordinator, and the head housekeeper.
We looked at records relating to the safety and governance of the service including accidents and incidents, medicines, staffing, and quality assurance. We also looked at four people's care records and 16 people's medicines records. We observed people being supported in one of the lounges.

Inspected but not rated

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Rating – inspected not rated, this is because this is the first inspection of a service that has not been inspected previously and only two key questions were looked at.

Systems and processes to safeguard people from the risk of abuse

● At the time of our inspection the local authority was carrying out a safeguarding investigation into the alleged neglect of a person at the service. Following our inspection, the local authority reported the safeguarding was proven. The provider contested this finding and was appealing against the local authority's decision.

● Two relatives said they didn't have confidence in the provider's safeguarding systems and processes. One relative said their family member was at risk due to an unresolved care issue and their records were 'so bad' the local authority safeguarding team had been involved. The relative said, "They are lacking in paperwork all the time." This issue had since been identified in the service's monthly quality assessment audit and addressed.

● The other relative said the service didn't tell them about a safeguarding incident involving their family member and they only found out about it because their family member mentioned it. They were concerned it hadn't been dealt with correctly and didn't know the outcome. This meant the service's safeguarding processes may not have been effective.

● Most relatives said people were safe at the home. A relative said staff kept their family member safe when they became distressed. They said, "[The staff] learned quickly to distract [family member] and be infinitely patient with them."

● Staff reported safeguarding incidents to the local authority and other relevant agencies. Staff were trained in protecting people from abuse and knew how to recognise abuse and report it.

Assessing risk, safety monitoring and management

● People had risk assessments for key areas of their care including nutrition, falls, tissue viability, moving and handling and choking. These were not always completed in a timely manner and records did not always show if people's care was provided as planned. The manager and operations director said care records were being audited and improved to ensure they were up-to-date and complete.

● Staff knew how to minimise risk to people and keep them safe. A relative said, "Our [family member] is safe and medically looked after. They do have occasional [infections] but not so often as before." Another relative told us, "We never had issues with [pressure] sores and we never needed the physio [physiotherapist]." A further relative said, "We know they are monitoring [family member's] weight and it is stable."

● Where people had DNAR (Do Not Attempt Resuscitation) forms in place there was documentation to support the decision. People's end of life preferences were recorded and if they did not wish to discuss this matter this was also recorded. This approach followed NHS end of life guidance.

● Staff provided people at risk of developing pressure areas with appropriate mattresses and cushions. The nurse on duty said care staff were good at alerting nursing staff to any signs of tissue damage so it could be

promptly treated.
● Visiting arrangements had varied in response to COVID-19 risk. At the time of our inspection, due to a local lockdown, only window visits were taking place. A relative said their window visit felt unsafe as they were standing on unstable ground and their family had to lean out to see them. The manager and operations director said they were planning to purchase wheelchair-accessible visiting pods for the winter to help ensure visits were conducted safely.
● The service had plug-in air purifiers in some communal areas and bedrooms. The two we checked were hot to touch and unguarded. The manager and director of operations said they would address this issue to ensure people were safe from the risk of burns.

Staffing and recruitment
● There was enough staff on duty to meet people's needs. There was a staff presence throughout the service. Staff assisted people with their personal care, socialised with them in the lounges, and accompanied them to an outdoor activity.
● A person being supported in their room told us, "You press the buzzer and [staff] come quickly unless they're with someone else in which case they put their head round the door and say that if it's not urgent they'll be back in a few minutes." The person needed two staff to help them mobilise and said two staff were always available to do this.
● There had been changes to the staff team. One of the nurses on duty during the day had been replaced with a senior care worker. The manager said this was because only a minority of people (eight in total) required nursing care at the time of our inspection, and the number of nurses would be increased if more people needed nursing care in future. The manager also said the provider was developing a clinical lead role to support the nursing team.
● Staff were safely recruited to ensure they were suitable to work at the service. The service carried out DBS (disclosure and barring scheme) checks and obtained references for staff prior to them beginning their employment.
● Two relatives said their family members had to wait for a long time for call bells to be answered. The manager said she listened out for call bells when she was on duty to ensure they were answered promptly. The service's monthly audit showed the manager checked the response time to a random call bell and it was answered in one minute and 20 seconds. The manager said call bell response times would continue to be checked to ensure waiting times were acceptable.

Using medicines safely
● Some improvements were needed to medicines management. The sharps container was not managed safely, dates were not recorded when it was opened so staff did not know when to dispose of and replace it. Some people had no protocols for their 'as required' medicines and the reasons these were given were not always recorded. Trans-dermal patches and covert medicines records needed improvement to ensure these medicines were being used safely and effectively. The manager said they would address these issues as a matter of priority.
● Staff administering medicines were trained to do so and had their competency checked. Medicines were securely stored at the correct temperature in a clean and tidy clinic room. Stock medicines were in date and eye drops and liquid medicines dated when opened to ensure they did not exceed their shelf life.
● People's medicines records were personalised and included a photo of the person in question and information about any allergies they might have. If people refused their medicines, the reason was recorded, and action taken as necessary

Preventing and controlling infection
● The service introduced new cleaning schedules in response to COVID-19 and the premises were cleaned

four times a day. The manager monitored cleanliness and audited cleaning records to ensure staff were preventing and controlling infection.

● The premises were clean, fresh and tidy. All staff wore appropriate PPE (personal protective equipment). New admissions were isolated for the required 14 days to reduce the risk of infections spreading.

● PPE was available outside bedrooms and disposal bins available in bedrooms. Bathrooms and toilets were well stocked with PPE.

● The reception area had PPE available for visitors to the home and there was a suitable container for disposal when leaving. Visitors had their temperature checked before being admitted.

● Staff were trained in infection control and had infection control policies and procedures to refer to. These were updated as necessary.

● People had their temperatures and oxygen levels checked daily although there were some gaps in records. This meant there was no record to show these checks had been carried out as planned.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

● Staff and managers responded appropriately when accidents or incidents occurred and used these as a learning opportunity. For example, after a person fell in their room, staff updated their care plan and risk assessment to ensure staff continually reminded the person to use their walking aid. They also arranged for the person to have a review with their GP to check if there was any other reason they might be falling.

Inspected but not rated

# 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.

Rating – inspected not rated, this is because this is the first inspection of a service that has not been inspected previously and only two key questions were looked at.

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

● Some care records had not been created in a timely manner. For example, one person, admitted in April 2020, had no care plan until August 2020. Another person, admitted in September 2020, had no risk assessments for four days, no nutritional care plan for 13 days, and no medicines care plan for 11 days. This meant staff did not have written instructions on how to care for people safely.

● There were gaps in some people's monitoring charts. Two people's re-positioning charts showed re-positioning was not always carried out at the required frequency. One of these people, who was meant to be re-positioned every two hours, had a gap of seven hours and 48 minutes on one of their September 2020 charts. This meant we could not be assured that all people's care needs were being met as planned.

● One person's fluid intake was recorded as being low (between 25% to 50% of the recommended amount) on five occasions in September 2020. There was no record of what action was taken to address this issue, or whether this shortfall related to record keeping or care issue.

● We discussed record keeping with the manager and director of operations. The manager said the service had gone from paper to electronic records at the end of February 2020. However, due to COVID-19, staff had only one training session and had difficulties using the new system. The manager and director of operations said this issue had not impacted on people's care. Since then staff have had more training and 90% of care plans were on the new electronic system.

● The manager and operations director said they would continue to monitor record keeping to ensure accurate and complete records were kept for each person using the service.

● The manager had a system in place to check/monitor the registration status of the nurses employed at the service. Nurse's registrations were in date, there was no restrictions on practice, and all were appropriately qualified to work at the home.

● The service had a registered manager who no longer worked for the provider but had not de-registered with CQC. The provider must address this issue to ensure they meet registration requirements. The manager was in the process of applying for registration with CQC.

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

● Most relatives we spoke with had concerns about how the service communicated with them. A relative said, "Communication could be improved, we could have a new [COVID-19] lockdown any time soon and we need to stay in touch with our relative, they should get a better system and keep us involved and informed."

● Some relatives told us no-one at the service had told them about current or future visiting arrangements. A relative said, "We don't receive any info or newsletters or anything [about] what is going on." Another

relative said they had dropped something off at the service and were surprised to find out that visits (at the time) were allowed. They said, "I didn't even know we could visit - they don't send us any updates at all."
● Another relative said communication from the service was so poor at the beginning of the pandemic they were 'worried sick' about their family member. However, they said it had recently improved. An activity co-ordinator had contacted them and they had received text messages and a video call with their family member.
● The manager said staff were under pressure at the start of the pandemic to meet people's care needs and did not always have the time to contact family members with updates and information. However, this situation had improved and more regular contact with relatives was taking place.
● Some relatives made suggestions about how the service could be improved, for example online relatives meetings, and more exercise opportunities for people using the service. A relative said, "It's all do-able if management would reach out to families and ask for ideas and opinions." The provider should consider ways of further involving people and relatives in the running of the service.
● The manager told us they had an 'open door' policy and staff could approach them at any time to ask questions or raise issues. Staff meetings and daily handovers took place to ensure important information was shared.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Most people and relatives were satisfied with the quality of care provided. A relative told us, '[The providers] are excellent. The staff are so caring. This is a caring organisation." Another relative said, "[Since being at the service] my family member's health has improved and they look better."
● The manager was helpful and approachable. A person said, "[Manager] is lovely. She listens and understands. She got me a better bed because the one I had wasn't right for me." A relative said she wanted to buy a hobby item for her family member and when she asked the provider if she could they insisted on buying it themselves. We saw this person enjoying their hobby item during our inspection.
● On the day of our inspection a visiting entertainer was singing to people in the courtyard. People were sitting outside to watch and join in supported by staff. There was a lively atmosphere and people were enjoying themselves, laughing and joking, and signing along to well-known songs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager and director of operations understood their responsibilities in relation to the duty of candour.
● The manager and director of operations notified the appropriate agencies, including CQC, of reportable incidents.

Continuous learning and improving care
● The service had improved staff support by employing a well-being strategy lead. They had one-to-one sessions with staff to check on their well-being and see if they needed any further support.
● The provider had introduced an employee assistance programme so staff could receive external advice and counselling as needed.
● The well-being strategy lead collected staff views on their induction, training, and experiences. This information was used to improve staff experiences when they joined the service.

Working in partnership with others
● The service had working relationships with other health and social care professionals and accessed support as required. For example, staff were responsive to fluctuations in people's physical and mental

health needs and sough specialist advice where necessary.

● Each person had a 'professional visits' log in their care records. These showed they had input from GPs, nurse practitioners, speech and language therapists, dieticians and other health and social care professionals as necessary.