Care Quality Commission

Sutton in the Elms Care Limited

# Sutton in the Elms

**Inspection report**

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

## Overall summary

We carried out an inspection on 10 December 2014. The inspection was unannounced. At our previous inspection in May 2014 we found that the service was not meeting three of the essential standards. These were standards relating to respecting and involving people; care and welfare of people and security of records. Since that inspection the provider has made improvements in relation to those standards, but improvements in respect of records had not been wholly sustained.

The service provides accommodation for up to 40 people who require nursing or personal care for older people, including people with dementia and people in the latter stages of their lives. At the time of our inspection 39 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and

# Summary of findings

associated Regulations about how the service is run. The registered manager left the service a few days after our inspection. Interim management arrangements have been put in place pending the appointment of a permanent registered manager.

The provider had procedures for protecting people from avoidable harm and abuse that were understood by staff. These included procedures for reporting and investigating incidents of alleged abuse and instances of people experiencing injuries. However, not all reported incidents had been thoroughly investigated to establish why they had taken place and how the risk of similar incidents happening again could be reduced. One serious incident that had been reported by staff was not properly investigated until after we brought it to the attention of the provider.

People's plans of care included assessments of risks associated with their personal care routines and welfare. However, a risk assessment had not been reviewed after a person had suffered a minor injury and they were exposed to the same risk on the day of our inspection.

People who used the service, relatives and staff we spoke with felt that not enough staff were on duty. The provider secured agency staff when permanent staff did not attended work which meant that staffing levels were down for short periods until agency staff arrived. However, at most times enough staff were on duty. The provider had effective recruitment procedures that ensured as far as possible that only suitable staff worked at the service.

People had their medicines when they needed them. The provider had effective procedures in place for the safe management of medicines.

Staff had not received sufficient support through supervision. Staff training was taking place but not in a coordinated fashion. This meant that many of staff had not been trained in some key areas. Supervision and staff training had not been coordinated. However, people who used the service were satisfied with the care and support they received.

The registered manager understood the relevance of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This is legislation that protects people who lack mental capacity to make decisions about their care and support, and protects them from unlawful restrictions of their freedom and liberty. The legislation had been used appropriately. This showed that the registered manager had a working understanding of the legislation. Staff training about MCA and DoLS was scheduled.

People's dietary needs were met, but some records of what food and drink people lacked sufficient detail. People were supported with their health needs. Staff were attentive to changes in people's health and arranged for health specialists to visit people when required.

Staff were caring and kind when they supported people. Staff understood and were attentive to people's needs. People using the service and relatives had opportunities to be involved in discussions about their care. People were able to spend their time as they wanted. Staff respected people's privacy. However, we did find one person's confidential records and notes concerning several people left in a communal area. We made a similar observation at our previous inspection and we required the provider to make improvements. Our finding at this inspection meant the provider had not sustained improvements to ensure that records were securely stored.

People were able to participate in and enjoy activities that they found meaningful and stimulating. Their plans of care were personalised and reflected their individual needs. Staff we spoke with understood the needs of people they supported. People and their relatives knew how they could raise any concerns they had.

The provider encouraged staff to raise concerns using a whistle-blowing procedure and incident reporting procedures. However some staff told us that they lacked confidence to approach the registered manager with concerns.

The provider had procedures for assessing and monitoring the quality of service, but these procedures had not always been effectively applied.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not consistently safe.

The provider had procedures for supporting staff to be able to identify and respond appropriately to concerns about people's well-being. However, a serious instance of neglect had not been properly investigated after staff had reported it. A thorough investigation occurred only after we brought the matter to the provider's attention.

**Is the service effective?**

Requires Improvement

The service was not consistently effective.

The provider had procedures for supporting staff through regular supervision, but those procedures had not been effectively implemented.

Staff were aware of the relevance of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and put that awareness to daily practice.

People were satisfied with the quality of food, but some thought food was not always served hot. People were supported to access health services when they needed to.

**Is the service caring?**

Good

The service was caring.

Staff showed kindness and compassion when they provided care and support. Staff respected people's dignity and privacy when they supported them. People who used the service and their relatives were complimentary about the staff.

**Is the service responsive?**

Good

The service was responsive.

People using the service had opportunities to express their views. Staff had good knowledge of people's individual needs and they provided care that met people's individual needs.

People were supported to maintain their interests through meaningful activities.

People were able to raise concerns through the provider's complaints procedure.

**Is the service well-led?**

Requires Improvement

The service was not consistently well led.

The provider had encouraged staff to raise concerns about the service but not all staff had confidence to do so.

# Summary of findings

| | |
|---|---|
| The provider had procedures in place for monitoring and assessing the quality of the service. However, those procedures had not always been effectively implemented. | |

# Sutton in the Elms

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 December 2014 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR and other information we held about the service. We also contacted the local authority to obtain their feedback about the service.

We talked with six people who used the service, four relatives of people who used the service and five care workers. We spoke with the registered manager, two assistant managers and the provider's operation manager. We looked at six people's care records. We also looked at a selection of the provider's policies, records of staff meetings and records related to the provider's monitoring of the service training records and management information.

After our last inspection in May 2014 we required the provider to make improvements in three key areas. These were: respecting and involving people who used the service; care and welfare of people who used the service and records. At this inspection we reviewed the actions the provider had taken.

Requires Improvement

# Is the service safe?

## Our findings

People who used the service told us they felt safe, but they felt that not enough staff were on duty at times. One person told us, "The girls [staff] are overworked. It's understaffed. The [staff] are rushed; I clearly see that they are overworked." Some of the relatives we spoke with shared this view. One said, "The staff are stretched at times."

Staff we spoke with told us that there were times when not enough staff were on duty. Comments from two staff included "There are not enough carers" and "We don't get more staff when we are short staffed." They told us that at these times they did not have enough time to spend what they called quality time with individual people, for example having meaningful conversations with them.

The registered manager decided how many staff should be on duty. They told us that their starting point was to ensure that there was a ratio of one care worker to five people plus two senior staff who were registered nurses and a manager. People's dependency levels were then taken into account and staffing levels were adjusted accordingly. Staff shortages had occurred at times when staff had not reported for duty. On those occasions agency staff were arranged but it had meant that for short periods on some days not enough staff were on duty until agency staff arrived. Staff told us they were busier during those periods. Our observations during our visit were that staff were not rushed. They attended to people's requests and responded to call bells promptly.

The provider had effective recruitment procedures that ensured as far as possible that only staff who were suitable worked at the service. All the necessary pre-employment checks had been carried out before new staff started working.

The provider had procedures for protecting people from abuse and avoidable harm. Staff we spoke with were aware of those procedures. We saw evidence that staff had used them and had completed reports of incidents where people had suffered an injury. However, not all accidents or injuries that had been reported by staff had been thoroughly investigated. Insufficient investigation had been carried out to identify why accidents or injuries had occurred. Action plans to prevent similar events happening again had not always been put into place. For example, a person who experienced a scald when eating soup shortly before our inspection almost experienced a similar accident on the day of our inspection. No action had been taken after the first occasion to understand it and to take steps to ensure that it did not happen again.

People's plans of care included risk assessments of activities associated with people's personal care routines. This meant that staff had information about how to support people safely and protect them from injury or harm. People were able to make choices about how and where they spent their time.

The provider had effective procedures in place for the safe management of medicines. The provider had effective arrangements for ensuring an adequate supply of people's medicines. They were stored securely and at the correct temperature which meant they were safe to use. Records we looked at showed that people had been given their medicines at the right times. People who required medicines for pain relief were given those medicines when they needed them.

Requires Improvement

# Is the service effective?

## Our findings

People using the service were complimentary about the quality of the staff and the service. Comments included, "The staff are wonderful, very good. I couldn't complain about them", "It's as good as it can get" and "I like it here." Relatives of people using the service were also complimentary. A relative told us, "I can't fault them, they've been marvellous, the nurses help and I'm very happy with the care." Other relatives told us, "This place is pretty good" and "They [staff] do a marvellous job."

We had mixed feedback from staff about how they were supported through supervision and training. A care worker told us they felt well supported and had been given opportunities to develop their career. The majority of staff we spoke with told us that they had infrequent supervision meetings. That was borne out by a supervision schedule we looked at. Of 60 staff supervision meetings that had been scheduled to take place before the date of our inspection, only 18 had taken place. Most care workers we spoke with told us that not having regular supervision meetings had not been detrimental to them. A care worker commented, "It's had no impact, but how does the manager know how we are doing things?"

The provider had arranged for staff to receive training through an external training provider. The training available covered a wide range of subjects that were relevant to the needs of people using the service. Staff selected training they wanted to do and completed training modules that were marked and evaluated by the training provider.

At the time of our inspection most staff had not yet received or completed training in the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. This is legislation that protects people who lack mental capacity to make decisions about their care and support, and protects them from unlawful restrictions of their freedom and liberty. Training was scheduled to take place early in 2015.

The provider had raised staff awareness about MCA and DoLS through a detailed summary that was sent to staff with their pay slips. Staff we spoke with demonstrated an awareness of MCA and DoLS, they understood that no form of restraint could be used without proper authorisation. Staff also understood that people had to give consent to care and treatment. Staff told us how they sought people's consent before providing care and support and we saw them do that in practice. Although staff had not received formal training in MCA and DoLS they had a good understanding of the legislation and were able to tell us how they put these into practice in their daily roles.

Most people we spoke with told us that they liked the food they had. Comments included, "The food is very good" and "The food is lovely". However, two people told us that their meals were sometimes not hot enough. When we observed a lunchtime meal we noted some people had waited at their dining table for an hour before they were served their meal from a heated trolley. Food temperatures were not tested before the food was placed on plates. . Another person told us "There's not a lot of variety of food and it could be cooked more."

Information about people's dietary needs was passed to the chef who was able to ensure that people with special dietary requirements, such as soft or pureed food, were met. People were able to choose what they had at mealtimes. For example the choice for lunchtimes was between two main meals. People were asked to choose what they wanted at lunchtimes the day before. The chef told us that was because food had to be ordered in advance. This meant that some people could not recall what they had chosen. We asked one person who was on their way to the dining room whether they knew what they'd be having for lunch and they replied they didn't know. The provider's arrangements for offering people a choice of main meals suited people who could recall what they had chosen but not for people who couldn't recall. However, before staff served meals they reminded people what they had chosen and people could, if they wanted, ask for an alternative meal. Staff told us that alternative meals could be prepared at short notice, for example omelette or salad. A person told us, "They [staff] are very flexible with the food." We noted that a person who declined a meal was able to ask for something that was not on the menu choice.

Staff kept records of people's food and fluid intake. That was important because it meant that staff were able to monitor fluctuations in people's nutrition which could indicate health issues. However, the quality of record keeping varied. We saw one record that had not been correctly completed. That record showed that a person had consumed more fluid than they had in fact been given. When we looked at that person's record shortly before lunchtime we found that it contained an advance entry

Requires Improvement

# Is the service effective?

about food provided at tea-time the same day. This called the reliability of the record into question. We discussed this with the registered manager who told us the forms would be redesigned to make them easier for staff to complete and reduce the risk of errors or omissions in record keeping about people's nutrition.

People were supported with their health needs. People's plans of care included information about any medical conditions they had and how they should be supported. Staff were alert to changes in people's health. Staff responded appropriately by alerting senior care workers (who were registered nurses) who, if necessary, arranged for doctors or other health professionals to visit the service. People were supported to attend health appointments with doctors, dentists, opticians and other health professionals.

Good

# Is the service caring?

## Our findings

At our previous inspection in May 2014 we found that not all staff treated people with consideration and respect. Not all staff spoke respectfully to people and staff had not always ensured that people were comfortable. That was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations. In August 2014, we received an action plan from the registered manager setting out how they would address this.

At this inspection we saw that staff treated people with kindness and compassion. A relative told us, "The majority of staff are caring." Staff were attentive to people's needs. We saw staff take action quickly when people appeared to be uncomfortable or showing signs of anxiety. They spoke politely with people and referred to them by their preferred name. Staff we spoke with had a good understanding of people's needs and life-history which had enabled staff to develop caring relationships with people using the service.

People using the service knew care workers and nurses names. We saw staff engage in meaningful and stimulating conversation with people. Staff and people using the service laughed and enjoyed each other's company. Relatives of people who used the service told us that staff treated their family relatives with respect. A relative told us they were very impressed with how caring staff were adding that, "Staff treated residents with respect, taking time to talk to residents and treat them as equals."

Relatives of people using the service were able to visit without undue restrictions. We saw from the visitor's signing-in book that relatives visited often and at different times of the day. Relatives were able to spend time with the people they visited in communal areas or in the privacy of their rooms or smaller quiet lounges. This meant that people's privacy was respected at these times.

The provider had effective arrangements for ensuring that when a person died their relatives were supported with kindness and compassion. We were aware that happened on the day of our inspection and we received very complimentary feedback from the relative's family about how kind staff had been.

People who used the service received help and support to be involved in decisions about their care and support. This was because people had an allocated key care worker. A key worker is a care worker who spends most time with a person and who developed a detailed knowledge of a person's needs. Key workers regularly reviewed people's plans of care and involved people, if they were able to be involved, in those reviews. Key workers were a point of contact for relatives of people using the service. A relative told us they felt involved in decisions about their parent's care.

People using the service and their relatives were provided with information about advocacy services. This meant should people have required additional support or advise the service had made this information available to them.

Good

# Is the service responsive?

## Our findings

At our last inspection in May 2014, we found that people's plans of care included details of people's assessed needs but lacked detail about how people were supported with those needs. People's care records had not been accurately completed and did not provide assurance that care routines had been properly carried out. That was a breach of Regulation 9 of the Health and Social Care Act regulations. We required that the provider took action to address this. In August 2014 we received an action plan from the registered manager which set out what steps they would take. At this inspection we found that people's plans of care and care records had been improved sufficiently to provide assurance that people's needs were met.

We saw from plans of care we looked at that people who were able to contribute to the assessments of their needs and the planning of their care and support. Were people had not been able, their relatives had contributed. Plans of care included information about people's needs and how they wanted to be supported. However, people we spoke with provided mixed feedback about the extent they were involved. A person told us, "They [staff] fill in their papers and they don't involve me." A relative told us, "Me and the family aren't involved in the care planning, we're not invited." A relative of another person told us they had been involved. Although some people told us they had not felt involved, they spoke in complimentary terms about the quality of care and support staff provided.

Care records we looked at showed that staff had supported people in line with their wishes and preferences. Staff we spoke with showed a good understanding of people's individual needs. Staff knew, for example, what people's interests and hobbies were. Staff knew what medical conditions people lived with. That meant that staff were able to provide care and support that was tailored to people's individual needs. The results of a survey the provider had carried out since our last inspection in May 2014 showed people were satisfied with the care and support they had received.

People using the service had opportunities to express their views about more general aspects of the service at `residents' meetings to which relatives were invited. Relatives had opportunities to make comments using comments cards, though none had done so. People's feedback at resident's meetings and surveys had been positive. The registered manager told us that an improvement that had been made as a result of people's feedback was the purchase of new crockery, for example cups, saucers, plates and bowls. A person using the service told us they enjoyed using the new crockery.

People using the service had been involved in discussions about the types of activities they wanted to be provided. A record we looked at listed a person's interests. That person had been provided with what they wanted to be able to enjoy their time. People were provided with tactile objects to hold which clearly provided them with comfort and enjoyment. We saw people spending time doing things that were of interest to them. That showed that people were able to spend time in ways that were stimulating and meaningful to them. We saw from recent records and photographs that people had made decorations for Christmas and had participated in Remembrance Day activities. In addition, almost half of the people using the service had participated in group activities such as bingo and an entertainments session provided by a visiting entertainer.

People told us they spent their time the way they wanted. A person told us, "I go to bed when I want to and get up when I'm ready. I choose what to do. I'm quite independent."

On the day of our inspection several people, including relatives, attended a coffee morning. We spoke with people about activities the service provided. They told us about visits to local schools where people enjoyed craft activities, visits to tea rooms and shopping centres. A person told us. "The activities coordinator is wonderful, brilliant." We found that the range of activities and the absence of restrictions on relative's visiting hours, protected people from social isolation.

Some people who used the service had faith needs that the provider supported them with. Representatives of different faiths regularly visited the home to support people with their faith needs.

People were able to discuss more general aspects of their care at residents meetings which were also attended by relatives. Relatives we spoke with told us they were confident they could speak with the registered manager or other staff if they had any concerns or wanted to make a suggestion. A relative told us, "The [management team] keep in touch with us pretty well."

Good

# Is the service responsive?

The range of activities and the absence of restrictions on relative's visiting hours, helped to protect people from social isolation.

The service had procedures that supported people using the service and relatives to raise any concerns if they wanted to. A complaints procedure was accessible to people. The registered manager told us that two complaints had been received since our last inspection. Both concerned equipment at the home and both had been responded to and acted upon.

Requires Improvement

# Is the service well-led?

## Our findings

At our previous inspection we required the provider to make improvements to ensure that documents which contained confidential personal information such as care records were securely kept. That was because we found three people's records in a communal area where unauthorised people could look at them. That was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. The registered manager told us in August 2014 that care records would be kept securely and that all staff had been reminded by a memorandum about the to the requirement of this regulation. However, at this inspection we found staff handover records and one person's care records had been left in a communal lounge for at least two hours. These documents contained confidential personal information. That meant that the steps taken to ensure the security of records had not been wholly effective.

After our last inspection in May 2014 four people who said they worked at the home contacted us anonymously with concerns about the service. Three of those people told us that they had not raised their concerns internally within the service because they lacked confidence to do so. Shortly before our inspection a fourth person told us of an instance of poor care practice that had occurred at the home. They told us they had used the provider's incident reporting procedures to report their concern but that their concerns had not been taken seriously. We raised this latest concern with the provider who immediately arranged an investigation of the incident. The investigation was thorough and established that a person had not received the care they should have received. Appropriate action, including disciplinary action, was then taken.

After we received the concern about the instance of poor practice we noted that the provider had not notified the Care Quality Commission of the allegation There is a requirement that such allegations are notified to us

The provider had, since our last inspection, encouraged staff to raise any concerns about the service through their whistle blowing procedures. We found that despite the provider's efforts to promote and encourage an open culture where staff could raise concerns internally, three staff had lacked confidence to do so, and one member of staff had not had their concern taken seriously. This meant the provider had more to do to ensure staff could confidently raise concerns internally.

People using the service and their relatives had opportunities to be involved in developing the service. People had contributed ideas about social and other activities at residents and relatives meetings. People's ideas and suggestions had been acted upon. For example, new crockery had been purchased for the use of people using the service as a result of their feedback.

Staff we spoke with told us they had not always felt involved in developing the service. When we spoke with a group of five staff, one told us and others agreed, that "staff meetings take place when we were going to get told off." Other staff told us, "There's a lot of fear" and "We don't complain, we don't give our ideas to the managers." Staff had infrequent supervision meetings where they could provide feedback. A care worker told us. "The managers don't come out of the office very often. They're not on the floor enough. It feels like it's a `them and us' regime." At our previous inspection in May 2014 the registered manager told us that a staff survey would take place later in 2014 to provide staff with an opportunity to give their views about the service. The survey had been rescheduled to begin in February 2015.

The provider had procedures for monitoring and assessing the quality of the service. These included scheduled checks and audits carried out by the management team and senior care workers. Monitoring activity included checking that people using the service received the care and support set out in their plans of care. Plans of care were regularly reviewed and kept up to date. People's feedback from surveys was used to help assess the quality of care.

Some monitoring activity had not been effectively carried out. An audit of first aid boxes had failed to identify that first aid boxes did not contain all the equipment they should have contained. A kitchen audit had not been followed up to address shortfalls despite audit procedures requiring follow up action to be taken. Monitoring of care records had not ensured that records were securely stored. We found that whilst the provider had effective procedures in place for monitoring and assessing the service, those procedures had not always been effectively used.

Requires Improvement

# Is the service well-led?

The service was managed by a management team comprising of the registered manager, two assistant managers and a team of seniors who were registered nurses. They were supported by an operations manager who visited the service several times a week. The provider informed us shortly after our inspection that the registered manager had left the service. Interim management arrangements were in place pending an appointment of a new registered manager.