Burlington Care (Yorkshire) Limited

The Sycamores

Inspection report

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15 August 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 14 and 15 August 2018 and was unannounced. This was the first inspection of The Sycamores sine the change of provider in February 2018.

The Sycamores provides care for up to 40 older people. At the time of the inspection 39 people were using the service. The Sycamores 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 although they were spending some of their time managing another of the provider's sister services. 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 2008 and associated Regulations about how the service is run.

The service was not safe because risks to people were not assessed or well managed. Staffing arrangements were not appropriate and new members of staff were not supervised and trained. Medicines were not managed safely. Safe recruitment practices were followed.

People were comfortable in their environment and had access to spacious communal areas and an enclosed garden. All bedrooms were single occupancy with en-suite toilets. However, there was a lack of bathing facilities and people told us they did not receive regular baths and showers.

People's care records contained very little information about what was important to them and their needs were not identified through the care planning process. People did not receive appropriate support with oral care. Staff did not have guidance around how to deliver personalised care. We have made a recommendation about improving accessible information to meet people's communication needs.

People's capacity to make decisions was not always assessed when needed, and were not always supported to have maximum choice and control of their lives; the policies and systems in the service did not support this practice

In-house and community activities were very limited although an activity worker had recently been appointed and the management team were confident this would improve people's social and leisure opportunities. People enjoyed the meals, and were offered regular drinks and snacks.

People told us they felt safe and well cared for. They were complimentary about the management and staff team. Our observations confirmed staff were caring. Health professionals told us people's health needs were met, and staff followed guidance and advice. Visiting relatives and friends were welcomed, and, where appropriate, staff and management provided information and updates.

The provider did not have effective systems to assess, monitor and manage the service. The provider had a system for investigating complaints and people told us they would raise concerns with staff and the management team, which included the registered manager.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014, which related to safe care and treatment, staffing, person centred care, governance arrangements and consent to care.

The overall rating for this service is 'Inadequate' and the service therefore has been place in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Care was not provided in a safe way. Risks were not assessed and appropriately managed.

Staffing arrangements did not ensure people were safe.

Medicine systems were not safe and people did not receive their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

Staff who were newly employed did not receive appropriate training and support. Staff who had worked at the service for a longer period were trained and supported.

People's capacity to make decisions was not always assessed when needed.

People enjoyed the food, and received plenty to eat and drink. Their health needs were met in most areas but they did not receive appropriate support with oral care

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring, and our observations confirmed this.

People enjoyed the company of others they lived with and staff.

Visitors were welcomed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not person centred and did not provide

sufficient guidance for staff about delivering care. The provider was introducing a new electronic care plan which the management team were confident would improve the care planning process.

Opportunities for people to engage in activities within the service and the community were very limited. An activity worker had been appointed which meant this should improve.

People were comfortable raising concerns and were confident they would be resolved.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager was assisting with the management of another care home which meant they were not able to robustly manage.

The provider's quality management systems were not effective and did not identify areas where the service had to improve.

The management team were responsive to the inspection findings and took prompt action to start addressing the concerns.

The Sycamores

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 14 and 15 August 2018 and was unannounced. An adult social care inspector and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included concerns we had received about the service in April and May 2018, and statutory notifications sent by the provider. We contacted relevant agencies such as the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We sometimes ask the provider to complete a Provider Information Return (PIR), which 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. On this occasion we did not request one and took this into account when we inspected the service and made judgements in this report.

During the visit we looked around the service and observed how people were being cared for. We spoke with 14 people who used the service, four visiting relatives/friends, three visiting health professionals, seven members of staff, the registered manager and the regional manager. We spent time looking at documents and records that related to people's care and the management of the home. We reviewed three people's support plans.

Inadequate

Is the service safe?

Our findings

Before the inspection we received some information of concern which included poor management of medicines. At the inspection we found medicines were not managed safely and people did not always receive their medicines as prescribed. The provider had recently changed their medicine system and used a different pharmacist which they said had caused some problems with the medicines but acknowledged this did not account for the level of issues we identified at the inspection.

We looked at six people's medicines and medicine administration records (MAR), and found errors with all six. We carried out stock balance checks of medicines that were dispensed from containers; these were often incorrect. For example, one person was prescribed a medicine to stop the build up of extra water in the body; their MAR indicated this had been administered 17 times so there should have been a stock balance of 39 but there was 48. The additional stock showed they had not received their medicines as prescribed. Three people were prescribed a medicine to treat constipation; the balance checks for all three were incorrect. Another person was prescribed a medicine which should have been administered twice a day for bone conditions; their MAR indicated on four days the previous week they had only received it once a day. It was not possible to do a stock balance check because the balance of tablets brought forward had not been recorded.

Staff were not always completing MARs appropriately. For example, they were not using the back of the MAR to record any additional information which should be used to explain any variation to the prescriber's instruction. If MARs were handwritten, one staff was signing the entry; this does not meet the provider's procedure which states two staff must sign to confirm this was checked and correct.

Most medicines were dispensed from medicine pods that were prepared by the pharmacist. We saw these were not always administered correctly. One person's pod included painkillers, which staff said they sometimes did not require. We saw, between 6 and 14 August 2018, staff had sometimes taken out medicines from the pod but left the painkillers and other times administered the painkillers. However, the MAR indicated the painkillers had not been administered during this period.

Staff did not always follow the prescriber's instruction. For example, one person was prescribed medicines to treat constipation which should be administered once a day. Staff were not following this instruction because we saw the person only received the medicine four out of the last nine days. Another person was prescribed a medicine to treat constipation which should also be administered once a day. They had not received the medicine in the last nine days. One person was prescribed a painkiller which could be taken up to four times a day. We saw this was administered daily between 6 and 10 August 2018; they had not received any painkillers after 10 August but when we checked their medicines we found there was no stock.

We checked two people's records and stock for prescribed topical creams and found errors with both. The deputy manager explained creams were stored in people's en-suite and everyone had a topical medication administration record (TMAR) which was kept with their cream. They also had a MAR which was kept with the main administration records This meant people had two administration records for each cream. One

person was prescribed a cream to protect the skin. The MAR kept with the main administration records was signed and showed this had been applied twice daily. However, the TMAR did not reflect the MAR, and showed the cream was being applied inconsistently, sometimes once a day and other times three times a day. The person also had a cream in their en-suite for dry skin conditions. A TMAR was in their room for the same cream but had no name, and had been signed by staff to show this had been applied. However, when we looked at the main MAR this was not a current prescription cream. The deputy manager said they thought the cream had been brought in by a family member and should not have been applied.

Some people had PRN (as required) protocols which should guide staff around administration. However, we saw there was insufficient information so staff would not know how to administer the medicines in a way that met people's individual needs and preferences. For example, one person's PRN protocol for painkillers just stated to be taken 'when in pain'. There was no detail about how staff would know, for example, if the person could say they were in pain. Other people did not have protocols. One person was prescribed a medicine twice a day as required to treat anxiety. There was no information to guide staff around administration. People who were prescribed topical applications did not have protocols that showed how they should be applied effectively in a way that keeps people safe, for example, the thickness of application.

Staff who assisted people with their medicines had completed relevant training. They had also had their competency assessed but this was not carried out annually as recommended by National Institute for Health and Care Excellence (NICE) guidance. NICE guidance provides recommendations for good practice for managing medicines in care homes. We concluded people's medicines were not managed safely.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns were raised about the staffing arrangements prior to the inspection, which included insufficient numbers of staff. At the inspection we found there was not enough competent, skilled and experienced staff to keep people safe. Some people who used the service, relatives and staff told us staff sometimes had to provide care in a timescale that made people feel rushed. One person said, "Staff have too much to do and not enough time to do it. When I ring the bell staff are normally very good." A relative said, "They could do with more staff. I had to speak to an agency worker, [name of person] was sitting on the edge of the bed trying to get to the chair, the agency worker thought this was ok. I had to tell them to get a regular member of staff."

Records showed at a relative and resident meeting in July 2018 the registered manager told everyone that the provider had increased the number of staff on duty from six to seven, however when we reviewed the rotas we saw only six staff usually covered the shifts between 8am and 8pm. The registered manager said they were increasing the number of staff but were not yet providing seven staff.

The registered manager was included on the staffing rota. Rotas for the last two weeks showed they had consistently worked at The Sycamores for 45 hours, however this was not the case because they had spent time covering another service. This meant the rota did not accurately reflect the management cover.

The registered manager said they had a dependency tool but this was last completed in May 2018; this meant they did not have up to date information about how many staff should be provided to meet people's needs.

On the first day of the inspection three staff were allocated to work in both units. Two care workers and the deputy manager covered the ground floor unit. The deputy manager spent much of their time administering

medicines, and when we arrived, they were carrying out medicine administration on the first floor. Therefore, two care workers were the only staff available to provide care and support to people. The two care workers who worked on the ground floor were new starters and commenced in July 2018. They had only completed two training courses which was basic life support, and moving and handling; one worker had not previously worked in the health and social care field. This meant the staff in this unit did not have the right skills or experience to support people to stay safe. We concluded the provider did not ensure sufficient numbers of competent, skilled and experienced staff were deployed.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not always appropriately assessed and managed which did not ensure people were safe. We reviewed people's care files which had a section with risk assessments which related to their care and support. These covered areas such as nutrition, continence, falls, mobility, moving and handling and the use of bed rails. However, some assessments were incomplete and other assessments had not been reviewed even though people's needs had changed. For example, one person had a nutritional assessment but this only included their weight. There was no further information to show if the person was at nutritional risk. Another person had an assessment for mobility that was last reviewed in May 2018; the equipment they used to aid walking had changed but their assessment had not been updated. One person's risk assessment stated they were at high risk of falls and the records showed they had recently sustained an injury when they had fallen. In the daily records we saw staff had recorded that a sensor to alert staff if they got out of bed was not working. A visiting relative told us their relative was at risk of falls, and a mat to help prevent injury should be in place at all times but when they visited this was not always the case. We concluded people did not received safe care and treatment.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found risk was not well managed, we saw examples where people's safety was promoted. For example, the management team had introduced additional security measures in response to one person leaving the home unaccompanied when this was not safe. Staff told us they completed relevant documentation when ever there was an accident or incident. We saw a member of the management team reviewed all accident and incident forms, and identified where action should be taken to help prevent any repeat events and learn lessons.

People lived in a safe and clean environment. We looked at certificates and service records such as gas installation, electrical wiring and fire safety equipment; these showed checks had been carried out to make sure the premises and equipment were safe. Weekly fire alarm tests were recorded and fire drills had been completed in May, June and July 2018. Fire safety equipment such as patient evacuation pads and extinguishers were located throughout the building.

Equipment for preventing the spread of infection, such as disposable gloves and appropriate handwashing facilities were readily available. In February 2018, the service had been awarded the top food hygiene rating of 'five' which means they were found to have 'very good' standards.

People who used the service told us they felt safe. One person said, "I feel safe, yes. Nobody here worries me. I would speak with any of the staff if I was worried." Another person said, "It feels safe here, it is ideal. It gives me a feeling of security at 90 years old, to be somewhere looked after, I feel safe and they care for me if I am ill, and the staff are wonderful."

All staff said they would feel comfortable reporting any issues around safety to the management team and had not observed any practices that had caused them concern. We received a mixed response when we asked staff about safeguarding training. Two new starters said they had not completed safeguarding training and were unfamiliar with the role of the safeguarding authority who are responsible for leading the local safeguarding system. When we brought this to the attention of the registered manager they arranged for both staff to complete the training. Other staff said they had completed safeguarding training and were familiar with the process.

The service did not have any information accessible to people about reporting concerns including abuse to the local safeguarding authority. The registered manager contacted the team and requested a poster.

We spoke with two staff who had recently started working at the service. They said they had gone through a thorough recruitment process to make sure they were suitable. They said they had attended an interview and references, employment history and Disclosure and Barring Service (DBS) checks were carried out. The DBS is a national agency that holds information about criminal records. We looked at two staff files which confirmed appropriate checks had been carried out before the members of staff were employed.

Inadequate

Is the service effective?

Our findings

New members of staff did not receive training to equip them with the appropriate skills, knowledge and experience to perform their job. Two staff who had recently started working at the service had completed an 'induction checklist'. This had been signed off by a member of the management team, and they had also completed two training courses, basic life support and moving and handling. We observed they worked unsupervised on both days of the inspection even though they had not completed sufficient training. The registered manager said no new starters had completed the 'Care Certificate' which is an identified set of standards workers adhere to.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who had worked at the service over a longer period of time told us they received good quality training which related to their role and responsibilities. We saw from the provider's training matrix staff had completed a range of training and the frequency to receive updates was monitored. Training included, fire safety, moving and handling, dementia awareness, safeguarding, health and safety, and infection control. The matrix indicated staff had not received training on equality and diversity, end of life care, confidentiality and nutrition. The registered manager wrote to us after the inspection and said staff who worked at the home before February 2018 had completed the training with a previous provider, and training was booked for the end of August 2018 which covered equality and diversity, person centred care, privacy and dignity, nutrition and fluids. We saw some staff were attending training with a local undertaker to help them understand what happens after a person dies.

Staff told us they generally felt supported by the management team and colleagues although some said they did not always receive regular formal supervision where they discussed issues that related to their work. We reviewed staff files which showed all staff had received at least two supervisions in 2018; the registered manager said all staff would receive at least six supervisions in a year which was the number identified as a minimum by the provider. However, this meant some would have to receive four supervisions in four months so their support sessions were not spread throughout the year.

Two members of staff who had recently started working at the home said they had received very good support from the deputy manager. One member of staff said, "[Name of deputy manager] has been really supportive. Another member of staff said, "At the end of each shift I'm asked how it's gone. If I have any questions I just ask [name of deputy manager]".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care

homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us three people had authorised DoLS, and none contained any specific conditions which had been identified as part of the authorisation. We looked at one person's authorised DoLS and saw a condition related to the frequency of visits from their representative. The Sycamores management team were responsible for monitoring this but it was evident from discussions they were unaware of, and not meeting, their responsibility. The registered manager agreed to follow this up and check if the other authorisations had any conditions.

People had capacity and consent care plans which stated if the person had capacity to consent and types of decisions they could make. However, we saw these did not always accurately reflect the person's ability to make a decision that could have serious consequences. Staff told us one person had sustained a fracture and since returning from hospital, which was nearly four weeks ago, they had stayed in bed because they were anxious. We saw from the care records the person was sometimes confused which indicated they might not understand how staying in bed could impact on their health and well-being. Their consent and capacity assessment stated they had been 'assessed as having capacity but since this date had been diagnosed with Alzheimer's'. The person's capacity about the decision to remain in bed had not been assessed and there was no best interest decision. We concluded people's capacity to make decisions was not assessed when needed.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood that they had a responsibility to assess if people agreed to care on a day to day basis, for example, if a person wanted to get up or go to the toilet. They said if a person was showing signs they were not agreeing to care they would discuss this with the person in charge of the shift. Staff told us they did not use restraint. One member of staff said, "If someone doesn't want to do something we leave them for a while and go back. We never force anyone."

We received positive feedback about the meals. One person said, "The food is very good, there is enough choice and enough of it, it is hot when it gets to you." Another person who had recently started using the service said, "I'm surprised how good the food is." Another person said, "There's plenty of food, it's good but I am fussy."

We observed people's dining experience on both days of the inspection and saw they received appropriate support. Tables in the dining rooms were cleanly laid with place settings, cutlery, condiments and napkins. Staff carried plates and dishes to each person. Food taken to bedrooms was carried on trays. The meal times were well organised, and there was a clear management system in place with one member of staff directing others. People enjoyed the food. They were offered choice and additional food and drink. We saw throughout both days, snacks and drinks were available. Fresh juice was provided in jugs to people in their rooms and we heard staff encouraging people to drink. We heard one person say to a care worker, "It's a good job you keep reminding me to drink."

We spoke with the cook who was knowledgeable about people's specific dietary requirements. They told us they were kept up to date with changes in people's dietary needs and were always informed when people moved into the home.

People told us their health needs were met. One person said, "I saw the GP yesterday who was very nice. A chiropodist does my feet." Another person said, "The GP and chiropodist and hairdresser all come, everyone

treats me with dignity and respect, yes, I tell them when they can come in. They are nice to visitors." A visiting relative said, "They are quick to call the GP if there's an infection, they took [name of person] to hospital once and called me."

We spoke with three visiting health professionals. They told us they did not have any concerns about the care people received and staff were generally good at sharing information about the people they were visiting. They said they received requests for support when appropriate and any advice was followed. One health professional told us medical supplies such as dressings were ordered in good time. We saw a notice displayed in the home informing people an optician would visit anytime.

We saw from two people's care records they had health checks and support from other health professionals to meet any specialist health care requirements. Health appointments were documented in one section of their care records to help monitor the support people had received. One person's health record was not fully completed so it was difficult to find out what support they had received. They had been discharged from hospital but there was no information about their discharge or the support they required. The registered manager agreed to follow this up.

Although we saw people had health checks we did not see any evidence people had received dental appointments. People did not have oral health assessments or oral health care plans which would help identify any prevent problems. We concluded oral care and treatment was not appropriate and did not meet people's needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People lived in a pleasant environment. Their rooms were personalised and everyone had en-suite toilet facilities. Some people spent time in their rooms others spent time in communal areas which were spacious. They had access to an outdoor enclosed garden but we did not see people use this during the inspection even though the weather was warm. People's rooms, and bathrooms and toilets were not clearly marked to differentiate them from other rooms. This meant it would be difficult for people living with dementia to navigate around the building and locate their room.

Bath and shower rooms were limited; two bathrooms were not in use because the bath chair hoist was being repaired so only one room with a bath was available for people to use. The service only had one shower room. This meant people who lived on the ground floor had to use the bathroom on the first floor if they wanted a bath, and people who lived on the first floor had to use the shower room on the ground floor if they wanted a shower. People told us they did not have regular baths or showers. One person said, "There are no showers, they are all downstairs. I have a wash, it's a long while since I had a bath or shower." Another person told us they had only had one shower. Two people said they had a bath once a week. We reviewed three people's bathing and showering records. These showed people did not have regular baths or showers. One person's record showed they had not had a bath in three months even though their care plan said they liked a bath. We looked at five people's bathing and showering records for June 2018; these showed people did not have a bath or shower. We concluded personal care was not appropriate and did not meet people's needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us they were happy with the service. They were complimentary about the management and staff team. One person said, "It's lovely here, there's a good atmosphere." Another person said, "Mr Steve [name of registered manager] makes sure we are all happy." One person described the member of staff who had helped them get dressed that morning as "very caring". A visitor said, "They are kind and caring." One person told us they had originally stayed at the service on a respite basis but had chosen to move in permanently.

People told us they were encouraged to make choices and gave examples of this. One person told us they decided when to get up and get dressed. They said staff would suggest nicely if they were late getting up. Another person told us they made every day choices. One person told us they liked the system of choosing their meals where staff asked them individually about 10am what they wanted to eat for the day. Another person told us they did not like the system and wanted to choose at the time their meal was served. Another person said they were offered something else if the meal "was not to their taste". We saw staff offering alternatives at meal times if people changed their mind.

People could choose where to spend their time. Communal areas provided adequate space for people to watch television or spend time with a group. People spent time in their room when they wanted privacy or to be alone or had visitors. Staff respected people's privacy by knocking on doors and calling out before they entered their bedroom or toilet areas.

We observed staff were kind and caring in their approach. They knew people well and chatted to people about their family members. Staff attended promptly to people if they heard them calling out or observed them needing attention. One member of staff noticed a person looked uncomfortable and spent time helping the person reposition. During medicine administration, the deputy manager explained the reason people were taking medicines. At one meal time staff chatted to people about their favourite singers. This generated group discussions and a sing along. Some people sang to music on the radio. We saw people were relaxed in the company of staff and others they lived with.

Although we identified people did not have regular baths or showers, they looked well cared for. Their clothes were clean and ironed. People's hair was brushed and they had clean hands and nails.

We saw a steady flow of visitors on both day of the inspections; staff and management were welcoming and provided information and updates where appropriate. One person who used the service said, "Visitors are welcome and they can make themselves a cup of tea in the kitchenette.

Staff's caring and committed approach was a key strength of the service, in spite of the shortfalls in all of the other domains and the weaknesses in the leadership and management of the home.

Requires Improvement

Is the service responsive?

Our findings

The management team explained that an electronic care recording system was being introduced so people's care plans, risk assessments and daily records would no longer be paper based. Staff were attending the first training day the day after the inspection and electronic daily records were commencing two days after the inspection. The registered manager said care plans and risk assessments would go live five weeks later which would ensure staff were familiar with the system and there would be sufficient information to generate person centred care plans and risk assessments.

We reviewed the existing care recording system and found people's care was not planned, and people's care and support records did not identify how their needs should be met. Some information was relevant although basic but other information was out of date and not person centred. One person's continence and mobility care plans stated they did not walk independently and used a stand aid with the support from two staff. However, we saw from our observations and the person's daily records they got up from a chair independently and walked with a frame. This included walking when staff were not around. The person was at risk of falls, however, there was no plan in place to manage this. Another person had a care plan for capacity and consent. This stated staff were to complete challenging behaviour charts and follow the person's PRN (as required) medicine protocol when a medicine to treat anxiety was administered. The person did not have a medicine protocol. There was no information about the type of behaviour the person displayed or approaches staff should use when the person displayed behaviours that challenged. We saw from the person's medication administration records that the medicine had been administered twice the week before the inspection. Staff had not completed any challenging behaviour charts. There was no explanation in the person's care records why staff had administered the medicines. We discussed the issues around care planning and delivery with the management team; they said they would consider the concerns raised and take appropriate action.

People's care records contained very little information about what was important to them. They had 'life maps' but we saw these were sometimes blank. The management team said the new electronic care planning system would include more information such as people's background, values and beliefs, communication needs, likes and preferences. People had advanced and end of life care plans; these contained very little information about the person's wishes, and staff often recorded the person did not want to address this issue at this time. This meant people who may be approaching their end of life might not be cared for in a way that meets their needs and preferences. We concluded people's care was not designed with a view to ensuring their needs were met.

People's social needs were not met. There was very little information in people's care records about their social interests and person centred activities. People had a social activities, religion and culture care plan but this contained insufficient information to show how people's needs should be met. For example, one person's last care plan review was carried out in May 2018; this stated the person had a flower arranging and exercise session in the month. There was no information provided for June, July and up to the date of the inspection in August 2018. Daily records showed when people had visitors but there was very little information about social activities.

We observed on both days of the inspection people sat for long periods with very little stimulation. No organised activities took place and no activity materials were freely available for people to access. Staff often went into the garden and talked with each other but people who used the service did not go out. The door to the enclosed garden was kept closed at all times and we did not hear any staff offer to accompany people outside even though the weather was pleasant.

People told us there was very little for them to do. One person said, "There aren't any activities." Another person told us they had sat outside, once, at the front of the service when a friend took them. They also said there had been someone with a "big ball bouncing" which they had enjoyed. Another person said, "I haven't heard of any activities. I played scrabble with someone but they fell asleep." They also told us, "I don't go in the garden as it takes staffs time and I feel guilty to ask. Someone from the church came in, they only gave five minutes notice; it was badly organised and there's been nothing since. One person told us, "I like watching TV but there's plenty to do if you want." We concluded people's social needs were not met.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager explained they had experienced problems recruiting an activity worker for quite a long period of time which had impacted on the level of social activities. They said they had recently made a successful appointment, and the activity worker would be providing an activity programme from the week after the inspection. One person told us they had met the activity worker was said they would be organising some 'trips out'.

It is a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. This is called the Accessible Information Standard. We saw the service had some information displayed to help keep people informed, for example, menus and an activity planner. However, these were not easily visible or presented in alternative formats, for example, large print or pictorial. After the inspection, the registered manager told us they had requested pictorial posters around safeguarding and abuse, and sourced some pictorial menus and were typing up daily menus in larger print.

We recommend that the service improves and further develops accessible information to meet people's communication needs.

People told us they would talk to the registered manager, other members of the management team and staff if they had any concerns. One person talked to us about a recent situation where they had a concern and had spoken with the registered manager. They told us it had been resolved. Another person told us they had spoken with the registered manager in the past and said, "It has made a difference." Another person said they would talk to the registered manager and described them as a "very nice chap". The complaints procedure was displayed near to the entrance of the service.

CQC had received some information of concern about the service before the inspection. This was shared with the provider at the time who carried out a formal investigation. The registered manager said they had not received any other complaints since the service was registered in February 2018.

The provider had received several compliments about the care they provided. Comments included, 'Thank you for your loving care to Mum. She loved you all', 'It is comforting to see how well the place is run. It is great to see there is so much continuity with the staff' and 'Knowing [name of person] was somewhere safe and treated with dignity, respect and kindness helped us as a family to be with her right to the end'.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager but they were not always present at the service. It was evident from the inspection findings there were weaknesses in the leadership and management of the service. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection they were assisting with the management of one of the provider's sister service which meant they were spending less time at The Sycamores. On the first day of the inspection they were at the provider's sister home but returned to The Sycamores when they were informed of the inspection.

People who used the service and relatives told us they knew the registered manager and said they managed the service well. Two health professionals described them as 'approachable'. Several people told us the registered manager responded to concerns and encouraged them to share their views.

During the inspection, a visiting relative raised a concern with us about the care their relative was receiving. The registered manager met with the visiting relative and went through the concern. They dealt with the issues sensitively and openly, and provided a solution which provided the visiting relative with a satisfactory outcome. The visiting relative told the registered manager they had wanted to discuss their concerns the week before but were told the registered manager was 'away'. The registered manager said all staff were aware even they were covering at another service they were always contactable. Two staff we spoke with said the registered manager was not always available and felt when they were at the service they spent too much time in the office.

People who used the service, relatives and staff had opportunities to attend meetings and share their views. We reviewed some meeting minutes, which showed information was shared by the management team about plans for the service. For example, staff were told during a recent meeting about the new care planning system. At a recent resident and relative meeting people were told about plans for the summer fayre. They were also told that the number of staff on duty had increased from six to seven, however this was not the case. The registered manager told us they were increasing the number of staff but were not yet providing seven staff.

In April and May 2018, we received three concerns about the service. These included poor management of medicines, insufficient staffing and the lack of presence of the registered manager. We asked the provider to look into the concerns at the time they were received. They told us they carried out investigations and the concerns were not substantiated. However, we found similar issues at the inspection to the concerns shared with us.

The provider had systems for monitoring quality and safety, however, it was evident from the inspection findings these were not effective. Medication audits were only carried out every three months. Care plan audits were completed and we saw examples where issues were identified. However, follow up actions taken did not ensure people's care needs were identified or met.

The registered manager completed a 'month end manager's report', which showed the registered manager was sharing some important information with the provider. The report covered areas such as pressure sores, nutrition, infections, hospital admissions, safeguarding referrals, compliments and complaints, and CQC notifications. The July 2018 report included people who lost weight, had an infection or had been admitted to hospital, and the outcome for example, referral to GP and infection cleared. However, this monitoring system did not ensure people received safe, quality care because it did not pick up the issues that we identified at the inspection.

The provider had carried out visits to the service. A visit report for June 2018 covered occupancy, staffing, recruitment and agency staff use. They had identified there was staff sickness and vacancies, and the home continued to use agency staff. However, there was no information to show how they had assessed that the staffing levels were meeting the needs of people who used the service. For example, there was no evidence of discussions with people who used the service or staff and no reference to the dependency staffing tool. We concluded the provider did not operate effectively systems and processes, and the systems and processes did not enable the provider to assess, monitor and improve the service or assess, monitor and mitigate risk.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On both days of the inspection, the regional manager, who was the registered manager's line manager, and had recently been appointed, attended the service. They supported the management and staff team during the inspection. They had visited the service at the beginning of July 2018 for an initial visit after taking over as the regional manager. The report showed they had discussed different aspects of the service which included, only one bath and shower room in operation due to replacing bath chair frames, transfer to the new electronic care recording systems and changes to a new pharmacy. The report also stated they had not covered some areas such as audits and activities.

The registered manager and regional manager were responsive throughout the inspection and told us the issues identified would be appropriately addressed. Training for new starters was booked, and on the second day of the inspection, a meeting with senior care workers and deputy managers was arranged to discuss the management of medicines. The regional manager stated the registered manager would no longer be taking on management responsibility for the provider's sister service although they said they would be still visit and carry out 'manager walk-arounds'. They said the registered manager would be focusing on managing The Sycamores. We also received a 'recovery plan', after the inspection, from the provider which showed actions they would be taking to address the key issues.

The registered manager told us they were developing stronger relationships with health professionals to achieve the best possible outcomes for the people they supported, and help prevent admissions to hospital. They told us they were working closely with the clinical commission group and a local GP practice to make sure people received a more consistent approach when they needed support with their healthcare. On the day of the inspection a member of staff who worked in the care homes support team was carrying out an assessment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not appropriate and did not meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make decisions was not assessed when needed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient numbers of competent, skilled and experienced staff were deployed. New members of staff did not receive training to equip them with the appropriate skills, knowledge and experience to perform their job.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not received safe care and treatment. People's medicines were not managed safely.

The enforcement action we took:

Warning notes

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effectively systems and processes, and the systems and processes did not enable the provider to assess, monitor and improve the service or assess, monitor and mitigate risk.

The enforcement action we took:

Warning notes