Ms Fola Omotosho

Sycamore Lodge

Inspection report

175 Faversham Road
Kennington
Ashford
Kent
TN24 9AE

Date of inspection visit:
28 June 2016

Date of publication:
17 August 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 28 June 2016 and was unannounced. At the last inspection in June 2013 we found the provider met the regulations.

Sycamore Lodge is registered to provide personal care and accommodation for up to four people living with mental health conditions. Sycamore Lodge is a detached house situated in a residential area of Ashford. There is a ground floor TV lounge/dining room, and kitchen and an upstairs quiet lounge, and bedrooms with ensuite bathrooms.
There is a large paddock and enclosed garden with a lawn to the rear of the building.

There were four people using the service during our inspection; who were living with a range of mental health needs. People required support and prompting from staff to help promote their independence and ensure their safety in their day to day activities.

This service is not required to have a registered manager in post. The provider has registered with the Care Quality Commission to manage the service and is therefore a 'registered person'. 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.

There were sufficient staff on duty to support the needs of people living in the service. The staff team was stable, most had worked at the service for several years, and worked well together as a team. Staff had received the training they needed to ensure people received the right support.

The procedure for recruiting new staff was done safely, with the proper employment checks being carried out.

The risks to people had been assessed and people's care plans reflected the individual goals and interventions required to keep people safe. There were robust policies in place to protect people from the risk of harm and abuse. Accident and incidents were recorded and lessons learned from them helped to improve care practice.

Medicines were managed safely and people received their medicines as they were prescribed them.

People were encouraged to make healthy eating choices and were offered other meal options.

People were supported by staff to make choices in their day to day activities and encouraged to be involved in their own care and treatment decisions. Staff were kind and respectful when supporting people. A range of activities were on offer and the provider and staff knew people and their preferences well.

People's physical and mental health needs were assessed regularly and referrals and appointments made

with the relevant health professionals as needed.

Staff understood how to respond to people's varying daily needs and to de-escalate behaviour that may affect the safety of people, while remaining kind and respectful.

The provider was supportive of staff and people and visited the service every day.

There were effective auditing and assurance processes in place to help identify any shortfalls in safety or quality. Staff enjoyed working in the service and felt able to raise any concerns or issues with the provider.

People were given opportunities to feed back about their experience of the service so that the service could constantly improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected by the service's recruitment practices and there were enough staff available to meet people's needs.

Staff knew how to recognise any potential abuse or risks to people and this helped keep people safe.

Sufficient checks on equipment and appliances had been carried out.

Medicines were managed safely. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff received effective supervision and training to help them to support people well.

Staff understood and worked in accordance with the Mental Capacity Act.
People were supported to make decisions about their care and treatment.

People were encouraged to eat a nutritious diet to minimise risks to their health. People had a choice of meals.

People were supported to maintain good health and to access other healthcare services when they needed them.

Is the service caring?

Good

The service was caring.

Staff supported people with consideration and kindness.

People were treated with respect and their dignity was upheld.

Staff encouraged people to be independent and treated them as

individuals.

Is the service responsive?

Good

The service was responsive.

There were a variety of activities available to suit people's interests.

People's needs were regularly assessed and staff knew how to support them.

People contributed to their care and support plans.

People and relatives were given the opportunity to make complaints or raise concerns.

Is the service well-led?

Good

The service was well led.

There were processes in place to monitor the quality of care and services provided to people.

The provider motivated staff to meet high standards of care and support for people.

People had opportunities to share their views about the service.

Sycamore Lodge

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 28 June 2016 and was unannounced. One inspector carried out the inspection.

Before our inspection, we asked the provider to complete 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 PIR and other information we held about the service, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with three of the people who lived at Sycamore Lodge. People were not all able to communicate their thoughts and feelings about life in the service, and not all wanted to speak with us. We therefore spent time observing their support and activity. We spoke with two members of staff and the provider. We spoke to two people's relatives and a social care professional.

We 'pathway tracked' three of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service and made observations of the support they were given, to get a picture of the care and support people received.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Good

Is the service safe?

Our findings

One person told us they felt safe at Sycamore Lodge. A relative we spoke to told us that their relative was not only safe but happier living there than anywhere they had lived previously. Staff told us 'people are in good hands'.

Staff had received training in the protection of vulnerable adults during their induction when they were new in post, and this was followed up by annual refresher training. Staff understood what abuse meant and were clear on the policy and procedure to follow to report abuse and how to 'whistle blow' if they had concerns about the safety of people. Staff knew where and when to access the contact details for the local authority safeguarding team.

There were enough staff on duty to meet peoples' needs. The daily minimum number of staff was two, to provide support for people with activities, going on trips and domestic tasks. One member of staff was present overnight on a sleeping duty, in case of emergencies. Additional requirements for staff were worked out by the provider on a rota based on what activities were planned, such as a medical appointment for a person, or a group outing. The provider visited the service every day to visit people and assess their support needs, and receive a report from staff. Staffing was reviewed if the assessed needs of people changed and a person needed one to one support, or in the event of staff absence. Staff at a sister service nearby were able to cover gaps on the rota and bank staff could be called in at short notice. The provider, or the senior carer was on call out of hours to support emergencies.

A safe recruitment procedure had been followed. Appropriate documentation checks had been completed, including employment checks, references, identity checks and a disclosure and barring service screening to ensure that people were protected from the risk of unsuitable staff being recruited. Staff turnover was low and agency staff were not used. Most staff had been employed in the service for at least a year; which helped to provide continuity for people.

Assessments had been made about a range of possible risks to people including medicines, exploitation or abuse and social isolation. We saw that actions to minimise the risks to people had been recorded and we observed these in practice. Staff we spoke with could describe ways of de-escalating problems, the importance of knowing people well in order to understand them and their behaviour, and identifying triggers in behaviour that could lead to people being harmed. Risk assessments were in place to describe how to support people if their mental health needs increased and staff reported at least daily on people's progress to the provider who is a psychiatric nurse, so that early treatment was accessed when necessary. Staff explained how they always warned people about trailing leads when they were hoovering and how no sharp objects must be accessible in the service. One person in the service smoked. There was no smoking allowed in the building, and this was accepted and agreed by people when they arrived. A clear risk assessment was in place that explained how support was to be given to the person so they could smoke in the garden safely, but independently. With their consent their cigarettes and lighter were held by staff for safekeeping but were provided on request.

People's medicines were stored securely in line with current guidance. The area was clean, tidy and well-organised; which helped to reduce the likelihood of error. Medicines were properly labelled, prescribed to individuals and in-date. Medicine administration records (MARs) had been completed fully and showed people were receiving their medicines when they were prescribed to have them. The MARs had been audited by the provider on a regular basis to ensure that people had received their medicines consistently. Medicines were administered in private and staff knew what action to take if they were refused. Staff had all received medicines training during induction and the provider regularly reviewed their competency so that staff understood the nature and effect of the medicines and could observe for side effects in people. Care files included accurate and up-to-date lists of people's medicines and assessments had been made about any individual risks associated with them. For example; when people refused to take their medicines there was a clear protocol in place for firstly explaining the benefits to people of taking their medicines regularly and for involving the GP if this approach was unsuccessful.

The premises were in good decorative order, warm and clean. Fire extinguishers and the fire alarm system and gas and electrical appliances had been checked and had current safety certificates. Fire drills were held every month and staff understood what to do in case of a fire. The provider told us that in the event of an emergency people would be evacuated to the sister service nearby. There were personal emergency evacuation plans in each person's care plan that described how to assist them in an emergency.

Good

Is the service effective?

Our findings

People told us they enjoyed the food on offer. We were told by a relative that they were happy that their relative was supported in their day to day life and that they had seen an improvement in their relatives well-being since they had arrived in the service.

Staff told us that the provider delivered personalised training on how to protect people, and how to support them as individuals. Staff stressed how important their training was in helping to understand the people they supported so that the possible triggers for behaviour that could lead to people being harmed would be minimised. The provider frequently carried out staff competency checks to ensure the training was effective and that people were receiving the right support.

Staff training included risk assessing the environment and relating every daily activity to the risk of potential harm to the people in the service. New staff followed an induction programme with an outside training provider covering mandatory subjects such as health and safety, the safe handling of medicines, fire safety, food hygiene, and the protection of vulnerable adults. They then shadowed other staff and learned about the policies and procedures they needed to know, until their competency and knowledge to support people was checked by the provider. Staff we spoke with said they felt well prepared for their role and that the provider's training was very thorough. Subsequent refresher training was provided in house by the provider which included, understanding the medicines in use in the service, the mental health conditions people lived with, how to reduce risk in the environment and how to support people with dignity and respect. New staff were signed up to complete the Care Certificate. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

Staff received planned supervision from the provider on a monthly basis to ensure that the staff had the right skills and knowledge and were clear about their roles. Additional supervision was given spontaneously if situations arose in which staff did not meet the expected standards of care. These sessions were recorded so lessons could be learned about how to improve future performance. We observed the provider checking on staff practice during the inspection. Staff later told us that 'there are good staff here and good training'. Staff also had annual performance reviews. We saw that one had been done in September 2015 and reflected the goal of the member of staff to be promoted. A supervision record in 2016 showed that this had been achieved.

People had enough to eat and drink and were supported to make choices about this. Meals were prepared by staff, who encouraged people to be part of the process, and people were involved in decisions about menus. Some people preferred 'fast foods' and to prevent health concerns staff encouraged people to choose nutritious food. Care plans were in place regarding people's nutrition, and staff monitored any significant changes in people's appetite or intake and contacted the GP if necessary. Information posters about making healthy food choices were displayed in the kitchen for people to see. The healthy choices menu which was planned was flexible, with people being able to choose an alternative meal. There were planned meetings every week so people could discuss what should be included in the menu and this was

recorded in a book which noted people's comments, such as, 'X would like more sandwiches, or 'X would like a roast during the week'. Drinks were available on request and also offered to people regularly through the day. During the inspection we observed breakfast where people enjoyed the cereal of their choice followed by the crumpets people had requested.

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Care plans recorded that staff should respect people's rights to make their own choices and to take informed risks. Formal agreement to care and treatment had been signed by people and was documented within care files. People who needed them had nominated representatives to help them make decisions about finances but all of the people using the service were able to make their own day to day decisions and care plans clearly stated this. We observed people making choices about daily activities. For example one person was asked how and when they wanted to do their laundry. The person explained how they were planning to do their laundry and in what order so that they had their favourite clothes available for wear as soon as possible. Even though they it was pointed out by staff that they normally chose to do this on a different day, and if they washed a certain item it would not be dry for later that day, we observed how the person's choice at that time was supported. One person had chosen to stay in bed late that morning and was on their way to the shower late, so staff checked they wanted breakfast before or afterwards. We observed that staff sought verbal consent from people before acting; staff asked if they could show the inspector people's bedrooms, and asked people what they wanted to do when they got in from their morning activity.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. No-one living at the service was subject to a DoLS authorisation and the provider and staff showed their understanding about the need to protect people's right to liberty. Individual risk assessments demonstrated the risk of people having their own front door keys. Some people had mental health conditions that could deteriorate rapidly and in those cases, and with their agreement, those people had not been given keys. However, we observed that staff promptly responded to let those people in and out of the house when the person asked to do so, which showed that people's liberty was not restricted. We were told that if a person requested a key their risk assessment would be reviewed. When people asked to go outside to smoke staff were on hand to open the door and supply the person's cigarettes and lighters.

De-escalation techniques were used to resolve any confrontation if people's behaviour changed. Care plans clearly showed how staff should respond if people displayed behaviours that challenged and staff gave us examples of how they supported people to reduce the risk of their behaviour changing and how they would act to de-escalate any mood changes people displayed. Staff were trained to understand how and why some triggers changed people's behaviours and staff told us how treating people with dignity and respect helped to minimise the triggers. We saw examples of avoiding trigger situations during inspection. Supervision records confirmed how the provider supported staff to understand people and their behaviours.

People's care plans contained the details of their mental health needs and how these were addressed by their psychiatric consultant. Information was clear about how their care and treatment was being provided, when they were to be reviewed, what other support was required, and what medicines they took. Care plans also detailed how a person's condition could worsen and what staff should do about this. Staff reported problems immediately and directly to the provider and there were clear guidelines in place as to how and when staff should contact the GP. The provider used their knowledge and experience as a trained psychiatric nurse to assess people on a daily basis and refer people to the community mental health team or the GP when necessary. People undertook supervised visits to the GP for routine health appointments such as well woman clinics, and also went to the dentist, and for eye checks, with the appointments being

recorded in a diary so that support staff could be planned for them.

Good

Is the service caring?

Our findings

We received nods and positive answers when we asked people if they liked their home, and the staff. Others we spoke with told us about the caring nature of the provider and staff and that they felt the standard of care given to them by the provider and staff was very high. A social care professional commented that, "the care people get is warm". A relative told us they had no concerns about their relative because "Their welfare was very well looked after".

The atmosphere in the service was calm and unhurried with people's routines being acknowledged and supported. Staff knew the communication styles of people. This was shown in how they spoke to people in a respectful way and used their preferred names, speaking clearly and ensuring that their comments were heard and understood. Staff were busy doing practical tasks in the service but spoke to people whenever they saw them, acknowledging what people were doing and providing assistance when it was needed.

People's rooms were decorated to their personal tastes. People were encouraged to clean their rooms, and help with some kitchen tasks and laundry. We were told this was to help promote their independence and help them understand the value of sharing living accommodation by taking responsibility. One person seemed pleased to show us their room when we asked if we could do so. They shared with us that they liked their room saying 'it was very nice and very clean', that they cleaned it, and that they liked living in the service.

We observed interactions between the provider and people that showed that people were well known and that their likes and choices were understood and supported. Care plans were created with people's input and contained clear goals that people wanted to achieve, the people they wanted in their lives and the interests they would like to pursue. The staff knew people well and spent time talking with them. We observed people talking to staff about their daily activities. If there were suggestions or plans discussed this was done fairly and clearly so that people understood any limitations and could make choices based on clear information.
People had meals together and some chatted quietly and some chose not to talk but that they appeared to be comfortable with each other.

One person spoke to us even though we were told they would not, saying that they liked living in the service. The provider felt that this was an indication of how much better the person felt and how much progress they had made. This was later confirmed by the person's relative.

Confidentiality and privacy was respected. Staff were careful to knock before entering bedrooms and asked if they could complete a task. Supervision records for staff reflected that confidentiality was important and that staff must behave accordingly inside and outside of work. The provider protected private conversations and details about people, with people's documents and care plans held in a locked office.

People could choose any staff member to be their key workers, whose role was to assist people with their shopping needs and support them in their leisure activities. Staff chosen could be from the sister service

nearby because staff worked between both services in order to get to know all people living in each location. Advocacy information was available to people on the noticeboard in the event of people requiring additional support to make their views known. Staff recognised this was an option for people, though it was currently not required.

Good

Is the service responsive?

Our findings

Before living permanently in the service people were invited to spend a period of time there on a trial basis and this helped ensure that they liked the environment and that their needs could be met.

The provider then worked with people, their social care professionals and healthcare team to create care plans that contained detailed information about people's life history, and family background and treatment. These held detailed information on the person's health care needs, the medicines they took, and the likely outcome and symptoms if the person's mental health deteriorated. The care plan included what goals people would like to achieve and what interventions would be necessary to help them maintain mental health. For example one care plan stated that a person wanted to go to the gym more often. These goals were reviewed every six months by the provider, with the involvement of the person. The provider facilitated reviews of people's care together with people, the professionals involved and where applicable, relatives, to ensure agreement with any changes in the person's treatment and care. A social care professional said to us that, "There is no blanket treatment. People are treated as individuals".
The provider had contact with each person daily, giving them the opportunity to say how they felt and if they needed any additional support. Verbal reports from staff to the provider, plus daily notes completed by the care staff that reflected people's well-being informed the provider about any changes in treatment, or staff support that was needed.

Monthly meetings were held informally for people together as a group. People were encouraged to put forward any topic of interest or concern and these were recorded, and showed people's ideas for meals to have, places to visit and other activities.

People enjoyed various activities at the service which were planned in advance in accordance with people's wishes. Most days there was a planned activity. These included occasional trips to people's preferred fast food restaurants, bowling, swimming, a day service, outings to animal parks, the gym and shopping trips. During the inspection a taxi was booked to take and return people to their day centre and people had lunch there. The afternoon was spent with people doing individual activities until tea time such as games, or watching TV uninterrupted by staff. Care plans recorded the activities that people liked to do and considered any risks of social isolation. People were encouraged to be sociable and not withdraw to their rooms where they could become isolated. Staff spent time doing activities with people, such as board games, baking or preparing meals and that staff also responded promptly when a person spontaneously wanted to go to the local shop to buy a snack.

People were encouraged to maintain their personal relationships. Care plans stated who people chose to have in their lives, and those that they wanted to exclude, so that staff would know how to support peoples' wishes. The provider had facilitated visits for two people with relatives they wanted to see and told us that this had benefitted their mental health. This was confirmed by a social care professional we spoke with who thought that this relationship building by the provider had been extremely helpful for the person. Relatives and visitors could visit freely however they were encouraged to make appointments in advance as people were frequently out doing activities.

There was a complaints policy in place which was displayed on the notice board for people to see and showed how the provider would respond. There were currently no complaints about the service. Relatives we spoke with said could contact the service at any time and that they found the provider approachable and supportive. People told us that the provider would help them if they had a problem. Residents meetings offered a forum for people to raise complaints and showed that if people had suggestions these were mainly about food suggestions and were addressed straight away.

Good

Is the service well-led?

Our findings

Staff said they enjoyed their job. "They said that they felt confident to raise concerns and that they would be listened to as, "The provider is easy to talk to about problems".

The values of the service demonstrated by the provider and staff in their day to day interactions with people, and in documentation, included involvement, compassion, dignity, independence, respect, equality, quality and safety. The provider demonstrated robust methods of training staff to treat people as individuals, including supervision records, training sessions and on the spot testing of staff knowledge. The provider also performed frequent checks on the care and treatment of people, with visits to the service during the day and out of hours to observe practice and to talk to people. Staff told us that they were well supported by the provider and that they understood their roles well. If mistakes were made the provider would respond by increasing training to ensure that staff were competent to support people safely. Staff handed over news of people's wellbeing and daily plans at a breakfast meeting every day and any problems were referred directly to the provider. Staff told us that everyone was kind in the service and that staff worked equally and together to 'create a home for people'.

The provider conducted monthly audits on medicines, staff training, supervisions completed, accidents and emergency drills. This meant they had oversight of staff competence in these areas to ensure that people were cared for by staff with the appropriate and current skills and knowledge.

There were no recent accidents or incidents to review, but the service policy, supervision records and speaking with staff told us that they knew how to respond to an incident such as an injury to a person or a fire. Older records showed that the provider took lessons learned from incidents to train staff in ways to improve their care practice.

Peoples' finances were reviewed daily to ensure that mistakes had not occurred, with staff checking people's money in and out and recording all transactions on a daily sheet. This process protected people from potential financial abuse and minimised the risk of mistakes.

Annual safety checks had been arranged by the provider and included areas such as fire alarms, extinguishers, boilers and exit routes, emergency lighting, showing that the environment and equipment would provide protection to people using the premises. First aid boxes had been checked for the correct contents. The provider was utilising a local authority checklist for keeping the kitchen area hygienic and food stored safely, and this was completed by daily by staff with all surfaces being disinfected, and food being checked for expiry dates.

Policies and procedures were in place covering most aspects of care delivery, and these had been written by the provider so that they were specific to the service and the people living there. These included keeping the environment safe, dealing with behaviour that could challenge others, emergency procedures, and the protection of people from abuse. These policies were available to staff and the provider recorded when staff had read them and demonstrated understanding of them.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The provider understood their responsibilities to notify the CQC of significant events and had none they needed to report.

People were asked for their views on a regular basis in order to seek and deliver any necessary changes to their care and treatment. This feedback was shown in books that recorded monthly meetings between staff and people, reflecting people's views on the standards of food, activities, and staff. The responses such as suggestions to places to visit were entered onto future activity plans, showing that what views people had would be considered and supported.
Peoples' relatives and other visitors to the service had been asked for their feedback in a survey in January, though the number of responses had been low. Staff had also been sent a survey to complete in May 2016 but not all responses had been received. Staff could respond anonymously and had the opportunity to present their opinion to the provider on any topic they chose.

The provider told us that they worked closely with the team of health and social care professionals and local authorities to ensure that safe practice and quality care and support was available and that people's needs would continue to be met. A social care professional confirmed this stating that the provider worked hard as an advocate for what was best for the individuals in their care and that, "We are really happy with how people blossom here and are definitely happier".