WCS Care Group Ltd

Sycamores

Inspection report

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Date of inspection visit: 22 July 2014
Date of publication: 07/11/2014

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. The inspection was unannounced.

The service provides accommodation and personal care for up to 36 older people who may also have a diagnosis of dementia. The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

At our previous inspection in December 2013, we found there was a breach in meeting the legal requirements for records. We found there were gaps in recording food, fluid and repositioning charts for people who were identified

Summary of findings

as at high risk. The deputy director of operations had already identified gaps in records as a concern during their recent internal audit. They were already progressing an action plan to address the issue.

During this inspection we found the necessary improvements had been made to meet the requirement for records. We saw food, fluid and repositioning charts were completed and up to date for the people whose care plans we reviewed. The handover matrix tool had been revised to include a twice weekly check and sign-off by the care manager or registered manager of key supplementary records for minimising risks to people's health.

All the people we spoke with told us they were happy at the home. They told us the staff were kind and helped them to maintain their interests and involvement in the local community. We saw staff understood people who were not able to communicate verbally and were compassionate and understanding with them.

People's care was centred around their individual needs because the deputy director of operations observed how people who could not communicate verbally responded to staff's actions. Care plans were regularly reviewed and staff asked other health professionals for advice and support when people's health needs changed.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). No one was under a DoLS at the time of our inspection. For people who were assessed as not having capacity, records showed that their families were involved in discussions about who should make decisions in their relation's best interests.

People who lived at the home and staff had confidence in the registered manager, who was supported by a hands-on management team. The service was accredited by relevant dementia schemes. The provider had consulted people and relatives in planned refurbishments which would improve the way people used the premises.

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?

Good

The service was safe.

All the people and relatives we spoke with told us they felt safe because they knew and trusted the staff. Staff understood their responsibilities to protect people from harm and the risks of harm.

The service acted in accordance with the requirements of the Mental Capacity Act 2005. No one who lived at the home was deprived of their liberty. People told us they were involved in discussions about how they were cared for and supported. The care plans we looked at showed that for people who did not have the mental capacity to make decisions, their next of kin, or legal representative signed their consent to care on their behalf.

We saw there were enough staff to care for and support people according to their needs. People told us they had the equipment they needed and staff were always available to support them.

Is the service effective?

Good

The service was effective.

Care staff received training that was appropriate to people's needs and had regular opportunities to discuss their practice and personal development with their line manager. The provider's training plan included training for care staff that was developed by experts in the field of social care and dementia.

Risks to people's nutrition were minimised because the service took advice and guidance from experts in nutrition to inform their menu planning. People had a choice of meals and snacks, and drinks were available whenever people wanted them. People told us they discussed their likes, dislikes and preferences at regular meetings.

People told us staff talked with them about their health needs and supported them to see their doctor and other health professionals when they needed to. Care staff monitored the health of people who were not able to communicate because of their complex diagnoses. Staff obtained advice and guidance from other health professionals when they had any concerns about people's health.

Is the service caring?

Good

The service was caring.

All the staff we saw were attentive to people's needs. We saw staff were kind and thoughtful in their interactions with people. People told us staff encouraged and supported them to maintain their independence and enjoy their life.

The service obtained guidance from external experts to make sure that people living with dementia enjoyed good quality life experiences. They used their observations to improve how people with dementia were cared for and supported.

People told us they liked living at the home and enjoyed shopping trips and day trips that staff organised for them. We saw that staff treated people with respect and promoted their independence. Relatives told us they could visit whenever they wanted to and their relations were happy and well looked after.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People's care plans were regularly reviewed and updated when their needs changed. People told us they were involved in discussing their treatment options and were supported to maintain their health.

People told us their comments and complaints were listened to and dealt with appropriately. The registered manager kept a record of complaints and the actions they took. They shared the information with the provider and used the information to make improvements to the service.

Is the service well-led?

Good

The service was well led.

Everyone we spoke with told us the staff were very good and their views on the quality of the service were valued. Staff told us they like working at the home and felt supported by the registered manager.

The quality assurance system included checks that the premises and equipment were maintained appropriately. Handover records between staff shifts were checked by the registered manager and the provider to make sure that staff understood their responsibilities.

The registered manager was supported by a proactive management team and had regular opportunities to reflect on their practice with a team of other registered managers in the group.

The service was accredited to appropriate nationally recognised schemes which promoted a learning culture. People who lived at the home were supported by a team of people who constantly strived to adopt best practice under the guidance of experts.

Sycamores

Detailed findings

Background to this inspection

The inspection team comprised an inspector and an expert-by-experience in dementia care. 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. We looked at information received from relatives and other agencies involved in people's care and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We reviewed the provider's information return. This is information we have asked the provider to send us to explain how they are meeting the requirements of the five key questions: is the service safe, is the service caring, is the service effective, is the service responsive and Is the service well-led?

During our inspection we spoke with the registered manager, the deputy director of operations, the care manager and six care staff. We spoke with seven people who lived at the home and two relatives.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex diagnoses. However, we used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We reviewed two people's care plans and checked the records of how they were cared for and supported. We reviewed three staff files to check staff were recruited, trained and supported to deliver care and support appropriate to each person's needs. We reviewed management records of the checks the registered manager made to assure themselves people received a quality service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe living at the home. People said, “Oh yes I feel very safe. I feel safe here. I’m very happy here” and “I know all of the staff.” Both relatives we spoke with told us their relation was happy at the home, and they had, “No concerns” about how their relation was cared for. One relative told us, “If I saw things that worried me I would talk to the manager.”

Staff told us they had training in safeguarding and knew what they should do if they had any concerns about people’s safety or welfare. Care staff told us, “If I was worried about something and it is not resolved, I would go to the next manager up.” Another member of care staff told us they had once referred an incident to the manager for safeguarding. They told us, “You have to, you’re their voice” and “The manager investigated and let me know when it was dealt with.”

We saw the registered manager kept a record of incidents that put people at risk of harm and referred people to the local safeguarding team when they identified risks to their safety. Of the three safeguarding notifications we reviewed, we found the local safeguarding team had noted that the registered manager took appropriate steps to minimise the risks of a reoccurrence of the incident and decided that no further action was required by the local authority safeguarding team.

In the two care plans we looked at, we saw the registered manager assessed risks to people’s health and wellbeing. Where risks were identified the care plan described the equipment required and the actions staff should take to minimise the identified risk. For one person who was identified as at risk of poor nutrition, staff kept daily records of how much the person ate and drank, as described in their care plan. This meant staff could monitor the person and would know if their health deteriorated.

One person we spoke with told us they understood the measures in place to keep them safe. They said, “I don’t ring a bell, but there is a pressure mat on the floor. I like the pressure mat in my room because it means that someone will come if I fall.”

We saw that when a person was assessed as lacking capacity, their representative had agreed that staff should make day to day decisions in the person’s best interest for nutrition, personal hygiene and for health care.

We found the registered manager understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).The DoLS make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The care plans we looked at included an assessment to check whether the plan would amount to a deprivation of the person’s liberty. The registered manager had not needed to apply for a DoLS for anyone living at the home because no-one’s freedom was restricted.

Care staff we spoke with understood the value of their training for managing behaviour that challenged. A member of care staff told us, “If a person declines, or resists personal care, sometimes you have to walk away for a while. If you can’t talk the person around, leave them for 20-30 minutes, then go back and start again - like a new page.” We saw this matched the instructions in the person’s care plan.

People told us there were always enough staff to meet their physical and social needs and they were supported to maintain their independence. One person told us, “Whenever I press the buzzer I always get help. The help comes along quite quickly Another person said, “The staff do all of my shopping. They buy me the things that I need. I can’t go out on my own because of my legs.”

Care staff told us, “We are busy but I do get time to talk to residents.” We saw care staff were in attendance in the communal areas throughout our visit. Staff engaged people in conversations and one to one activities that interested them. The care plans we looked at were reviewed monthly and included a dependency needs score. The deputy director of operations told us they used the aggregated dependency scores to decide the staffing levels to make sure everyone’s needs could be met.

In the three staff files we looked at, we saw records of the checks made before staff were employed. The registered manager obtained two written references, photographic identity documents and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that holds information about criminal records.

Good

Is the service safe?

We saw staff's qualifications, skills, abilities and behaviours were assessed during the recruitment process. Staff received initial and ongoing specialist training to make sure they were competent to deliver care appropriate to people's needs.

Good

Is the service effective?

Our findings

The deputy director of operations told us all staff had a workforce development plan to encourage learning and personal development. They showed us the provider's rolling programme of training. We saw that training courses were scheduled every month for staff across the provider's group of homes. This meant that staff were able to attend training as soon as they started working at the home. The registered manager kept records of each staff's attendance at training so they knew when staff should attend refresher training.

Care staff we spoke with told us about the training they attended. One member of care staff told us, "We have training in health and safety, fire, food hygiene and first aid. I have dementia training planned and I would like end of life training." Another member of staff said, "In the manual handling training I went in the hoist, so I know how it feels." This meant staff received specialist training appropriate to the needs of people who lived at the home.

Care staff told us they felt prepared when they started working independently at the home because they had a comprehensive induction programme. The induction programme included training and shadowing experienced staff. One member of care staff told us, "I completed a four day training course which included a question and answer booklet, watching other staff and reading care plans." Another member of care staff told us, "I read the care plans and I got to know them (people who lived at the home) well."

Care staff told us they were encouraged and supported to gain nationally recognised vocational qualifications, which developed their skills and understanding in supporting people and enabled them to consider their own career progression.

Care staff told us they knew whether they were doing a good job because, "The residents tell us and we have appraisals every six months." They told us they had regular opportunities to speak with the care manager and registered manager. The three staff files we looked at included notes of staff's annual appraisal meetings with the registered manager. We saw they discussed staff's achievements, areas for improvement and personal preferences for developing their role. Care staff told us they had regular one-to-one meetings with the manager. Care staff told us they were confident they could talk to the manager at any time. One member of care staff said, "I could go straight to the manager about anything" and "It has improved since he has been here."

People and relatives told us staff knew about their dietary preferences and nutritional needs. We saw people's needs, allergies, likes, dislikes and preferences were recorded in the two care plans we looked at. One person told us, "I don't like sugar in my coffee. The staff know this and so they don't give me sugar." People told us they had a choice of meals. One person told us, "There is always coffee and biscuits. They keep us supplied with drinks and so on" and "In between times I can always have a drink and a biscuit."

We saw the registered manager assessed people's nutritional needs when they moved into the home. Menus were planned using a recognised nutritional analysis tool, which calculated the essential food groups and vitamins contained in a measured amount of each ingredient in a meal. This meant the provider knew that people were offered meals that contained a range of the essential food groups every day.

At lunch time a member of care staff showed us the list of meal choices for each person. We saw the list was coded to indicate a pureed meal for people who needed a soft food only diet. The member of care staff told us, "People chose yesterday what they would like for lunch. [Name] is diabetic, their custard is marked" and "[Name] went to the chiropodist this morning, so missed her morning sleep. We have put her lunch aside and will offer it later." This meant staff knew about people's dietary needs and supported them to maintain an appropriate diet.

We saw two care staff assisting two people to eat, because they were unable to eat independently due to their complex needs. We saw one member of care staff called the person's name and stroked the back of their hand to get their attention. The care staff kept up a continuous explanation about what they were doing and encouraged the person to eat. The care staff we saw assisting people to eat were patient and gave people time to appreciate the flavour and texture of their food. Relatives we spoke with told us the atmosphere in the home was always the same and they always saw people being served and supported effectively at meal times.

Relatives told us they felt well informed about their relation's health and welfare. They said their relation saw

Good

Is the service effective?

their usual GP and staff discussed treatment options with them. People's care plans and communication diary showed when other health professionals visited people, such as doctors, dieticians, speech and language therapists. A member of care staff told us, "I always read the communication handbook. I can catch up with the reading from when I was not here." This meant that people were supported to maintain their health.

Staff kept daily records so they could monitor changes in people's health, moods and behaviours. For one person who was at risk of poor mental health, we saw staff kept detailed records, or behaviour charts, to identify possible triggers for when the person presented challenging behaviour. The charts recorded the probable trigger, what happened and the action taken by staff. The care manager reviewed the records to identify patterns. The care manager was able to use the charts as evidence when they asked the community mental health team (CMHT) to visit and review the person's needs for support. This meant staff recognised when people's needs changed.

Handover was both verbal and written, which meant people's risks were known by all the staff. Care staff met with the care manager and shared information about people's health, moods, behaviours, appetites and the activities they had been engaged in. A member of care staff told us, "We have an in depth handover and we are told to read the care plan if something changes." All staff signed a daily log which acknowledged that they knew and understood people's needs and their responsibilities for actions they should take. People and relatives told us, "Staff know what they are doing."

Good

Is the service caring?

Our findings

People and relatives told us the staff were very kind. One person told us, “There’s no place better than this. This is the best one.”

We saw that the initial assessment of people’s needs included a recognised assessment tool which measured how people responded to 41 different everyday activities. This meant staff could understand people’s individual likes, dislikes, hobbies, interests and goals, if they were unable to articulate them because of their dementia. A second recognised assessment tool, developed by an occupational therapist who specialised in dementia care, was used to measure people’s level of engagement with a list of everyday activities. People’s abilities were assessed as planned, exploratory, sensory or reflex. The deputy director of operations told us they used this information to create a personal profile and to plan appropriate activities for each person. A member of care staff told us they were able to match staff as keyworkers for people because, “We have a list of staff’s interests.”

Care staff we spoke had a good understanding of the value of the assessment tools. One member of care staff explained it helped them understand people who were not able to say what their preferences were. They told us if a person’s ability was assessed as sensory, “We encourage feeling, touching objects, classical music, one-to-one activities, such as, stroking animals or sitting in the garden, and review the impact. We try to encourage people to join in shared activities.”

We saw staff kept life diaries for each person. In one person’s diary we saw photos of the person engaged in activities, such as live music events, making hats and celebrating the national care home open day. Care staff told us, “We write about what they have done that day. We are also encouraging their families to write in there too. We add photographs and the children will draw pictures.” The life diaries were kept in people’s own rooms so they and their relatives could find them and use them to promote conversation and memories.

People told us they were involved in discussing how they were cared for and supported and their decisions were respected. One person told us, “I had the opportunity to explain how I wanted to be cared for when I moved here. We saw people who could not move around independently were encouraged and supported by staff to change position and room.

Both relatives we spoke with told us they felt welcome to visit when they liked. One relative told us, “I visit every day. It’s just like home from home.” They told us they could sit in a private space if they wanted to. One person told us, “When I want privacy I go to my own room.”

People told us staff respected their privacy and encouraged them to maintain their independence. One person told us, “I can’t go out easily but the nurse took me out the other day to the shop” and “We all go out on trips for a meal sometimes, about once a week. I really like that.” Another person told us, “When I walk I fall over and so they take me out in a wheelchair. I go to the shop to buy a newspaper or they take me to feed the ducks.”

Good

Is the service responsive?

Our findings

People we spoke with told us they were supported to see other health professionals when they needed to. They told us, “I see the doctor when I need to. I have been in hospital a couple of times”, “Yes, I see the dentist and the optician” and “Staff discuss options with me and the doctor comes regularly. I also see the optician.”

We saw staff recorded in people’s care diary when they had appointments with other health professionals, such as the chiropodist, their doctor and the falls clinic. A member of care staff told us, “I will call a doctor for a resident myself. The care manager organises the other appointments, such as the occupational therapist, the community mental health team and dentist.” This meant people received treatment when they needed it.

Relatives told us they had no concerns about how their relation was supported and felt comfortable about raising any concerns. They were confident their concerns would be taken seriously. A member of care staff told us, “I talk to people about their worries. If it needs to be taken further I will help them to write it down and give it to the registered manager or care manager.”

People who lived at the home, relatives and staff told us they felt informed and involved in their care and how the home was managed. Care staff told us, “We have monthly meetings, team meetings, unit meetings. It varies as needs” and “We have all been involved in the unit refurbishment, chosen wallpaper and curtains.” The meeting minutes we looked at showed that people who lived at the home had discussed the planned refurbishment of the communal areas and were looking forward to spending time in a modernised and up-to-date environment. One person told us, “This home is not like the ones that you see on the television you know. They listen to me.”

People felt confident their complaints would be treated seriously and knew they would not be discriminated against for making a complaint. One person who lived at the home told us, “I have complained in the past. Whenever I complained my complaint was dealt with very well. I used to complain a lot. They probably thought that I was a bit of a complainer. I don’t complain anymore. The staff are nice. There’s no trouble with the staff here.”

In the registered manager’s complaints log we saw that verbal complaints were logged as well as written complaints. The registered manager had recorded the details of the issue, the results of their investigation and the action they had taken to resolve the issue. We saw they met with the complainant to explain what they planned to do to make sure the action was acceptable to the complainant. We saw the deputy director of operations checked that complaints were dealt with appropriately and to minimise the risk of the same issue arising in the future.

Good

Is the service well-led?

Our findings

People and relatives we spoke with told us they had confidence in the management and staff. They said they felt involved in how the home was run because they were invited to meetings and were asked to take part in surveys. Relatives told us the manager was a visible presence when they visited. People who lived at the home told us, "I like living here" and "Everything is fine here, the cooking and the washing. There's nothing to grumble about here."

We saw a copy of the booklet that was given to every person when they were deciding whether they would move into the home. The booklet explained the provider's vision and values, how the home was managed, what people could expect, the provider's policies and practices and how complaints were handled. During our inspection we saw the registered manager and care staff worked within the framework described in the booklet.

Care staff we spoke with told us they felt supported by the registered manager and leadership team because they were always approachable. Staff turnover at the home was minimal and 93% of the staff had been in post for over a year. The service operated an on-call system for supporting staff out of office hours. The on-call rota included members of the executive team and their mobile telephone numbers. This information was written on the front of the shift handover book where everyone could see it.

The deputy director of operations stayed on site throughout our inspection to support the registered manager. They explained the provider's refurbishment plans would improve how the premises would be used. For example, the kitchen refurbishments would enable people who lived at the home to be involved in a wider range of domestic activities safely and staff would be looking out into the communal areas while completing domestic tasks.

All the staff we spoke with told us they liked working at the home because they enjoyed working with the people who lived at the home. Care staff told us, "We ask people at the start, or ask families, and try and assess (their social needs) for ourselves" and "Keyworkers update care plans at monthly reviews. I can challenge if the care plan doesn't make sense or is inaccurate." This meant that people's written care plans were reviewed and updated by people who knew them best.

The deputy director of operations checked whether the care and support people living with dementia received led to a state of wellbeing, by using a dementia care mapping tool, recommended by the Social Care Institute for Excellence (SCIE). They shared their analysis with the keyworker and care manager to consider and agree what improvements could be made to people's care plans.

The provider's information and quality monitoring system included a comprehensive handover log, which recorded incidents, accidents, visits from other health professionals, medicines administration, housekeeping and a matrix of key information and risks for each person who lived at the home. Risks that were monitored included critical needs, such as controlled drugs, warfarin, diabetes and oxygen and the use of sensor alarms. The handover log was used by all staff to sign in and out and named the individual staff responsibilities for each shift.

Care staff told us they knew about the whistleblowing policy. A member of care staff said, "I could challenge poor practice. I would say, 'What you just did wasn't right'. Afterwards I would tell the senior what happened and what I said. If there is a problem I can't deal with I would go to the care manager."

Since our previous inspection, when we identified concerns with record keeping, we saw the provider had taken action to minimise the risk of records not being kept up to date. When people were identified as at high risk, and staff were asked to monitor particular aspects of care, by completing food, fluid and repositioning charts, this was included in the handover log. The senior in charge had to sign to show that they had checked that monitoring records were completed when they signed as the responsible person for the shift.

Staff at all levels had a role to play in the provider's quality monitoring system. We saw the results of a continuous programme of checks and audits undertaken by various members of the staff team. Housekeepers undertook checks of the laundry, fire alarms and specialist equipment; senior care staff undertook medicines audits; the registered manager analysed accidents, incidents, near misses, falls and complaints. The provider monitored the audits and actions taken as a result.

We saw the results of the provider's monthly compliance visits. Where issues were identified the provider checked that actions were completed and effective at the following

Good

Is the service well-led?

visit. The registered manager was invited to attend regular meetings with other registered managers in the provider's group. We saw the agenda included opportunities to share good practice with peers and to discuss plans to improve the quality of the service, to be cascaded to staff at staff meetings.

The service was recognised by the Investors In People (IIP) and an accredited member of initiatives in care, such as, the National Association for Providers of Activities for Older People (NAPA), Dignity in Care, My Home Life and Dementia Care. This showed commitment by the provider to learn from the experience and knowledge of others to enable the best possible outcomes for people who used the service and staff.